DAILY COMFORT MASSAGE

Health History Form **Tori Nation, LMT**

An accurate health history ensures that it is safe for you to receive a massage treatment, and helps the therapist determine a proper treatment plan. **When your health status changes in the future, please let us know**. All information gathered on this form is confidential. Your written authorization is legally required before any of this information can be released.

Personal Information

Name: _____ Date: _____
Address: _____
City: _____ State: _____ Zip Code: _____
Phone: _____ Email: _____
Occupation: _____ Date of Birth: ____/____/_____ Male/Female/Other_____
Emergency Contact Name: _____
Relationship: _____Phone: _____

Have you had a massage before? (Yes) (No) For relaxation or other reason? _____
_____
Are you currently receiving medical treatment for any reasons or have any health concerns at the present time?
_____
_____
_____
Are you currently taking any prescription or non-prescription medication, natural remedies or supplements?
Please list._____
_____
_____
Have you had any major surgeries? If so, please list when these surgeries were performed._____
_____
_____

From the list of conditions below, please check which of the following condition(s) you have been treated for in the past, as well as those condition(s) in which you are currently being treated.

☐ Cancer ☐ Diabetes ☐ Arthritis ☐ Carpal Tunnel ☐ Allergies ☐ Heart condition ☐ Infectious Disease ☐ Liver Disorders ☐ Multiple Sclerosis ☐ Circulatory Issues ☐ Seizures ☐ Headache/Dizziness ☐ Respiratory Disorder ☐ Phlebitis / Thrombosis ☐ Psychological Conditions ☐ Skin Condition ☐ HIV / Immune Disorder ☐ High/Low Blood Pressure ☐ Alcohol/Substance Abuse ☐ Other(s):_____
Please Explain: _____
_____
_____

Lifestyle Questions

What type of lifestyle do you currently live? ☐ Very active ☐ Moderately Active ☐ Not Active

What is your current stress level? ☐ High ☐ Moderate ☐ Low

Reason For Visit

What brings you into the office today?_____

When did your symptoms begin?_____

How often does this discomfort bother you? _____

How long does it last? _____

Is there ever a time when this discomfort does not bother you?_____

How would you describe the discomfort? (Ex: Sharp, stabbing, achy, dull). _____

Do you have any numbness or tingling in the arms or legs?_____

Does your discomfort radiate down the leg or arm? _____

Is there anything you find relieving (ex: ice, heat, rest)? _____

Is there anything you find aggravating (ex: standing, bending over)? _____

Have you received treatment/surgery for your current complaint? If so, from whom?

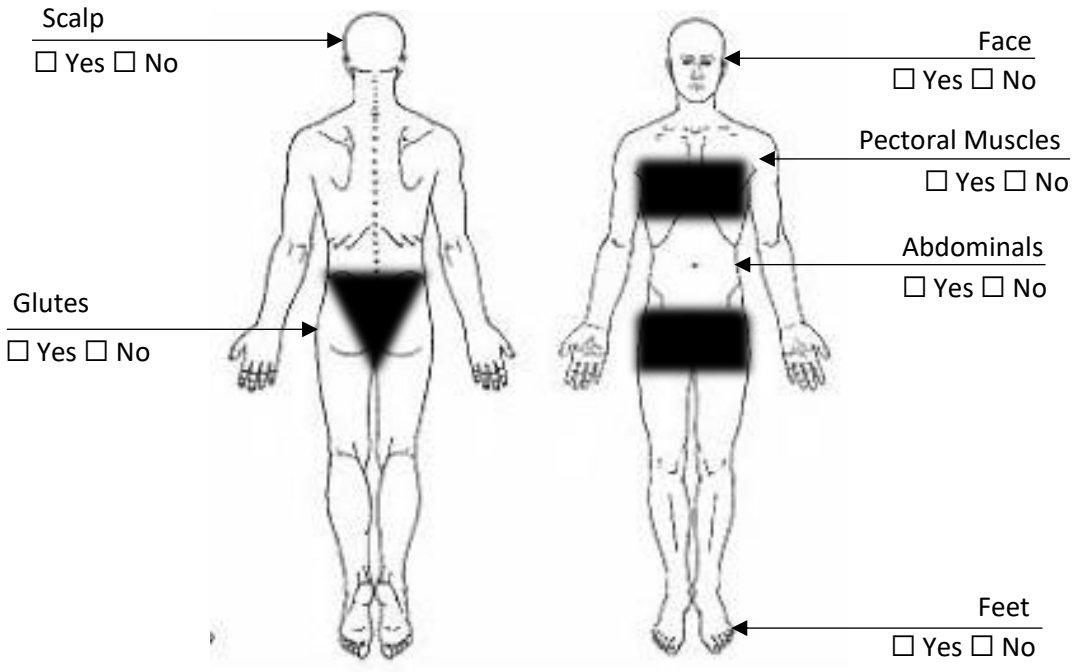
_____

Are you currently pregnant? ☐ Yes ☐ No Due Date? _____/_____/_____

Postpartum less than 6 months? ☐ Yes ☐ No Birth Date? _____/_____/_____

Please indicate the areas you **DO** and **DO NOT** feel comfortable being massaged:

If you have any questions about specific areas, please ask the therapist to elaborate



Areas that are blacked-out (breast tissue, groin/genitals, gluteal cleft/anus) are areas that will never be undraped or touched during any massage

Informed Consent to Massage Therapy Treatment

Please read carefully, and sign.

- I understand that the Massage Therapist is providing massage therapy services within their scope of practice as defined by the Massage Therapist Association of Washington.
- I hereby consent to my Therapist to treat me with massage therapy for the above noted purposes including such assessments, examinations and techniques, which may be recommended, by my Therapist.
- I acknowledge that the Therapist is not a physician or chiropractor and does not diagnose illness or disease or any other physical or mental disorder.
- I clearly understand that massage therapy is not a substitute for a medical examination.
- It is recommended that I attend my personal physician for any ailments that I may be experiencing.
- I acknowledge that no assurance or guarantee has been provided to me as to the results of the treatment.
- I acknowledge that with any treatment there can be risks and those risks have been explained to me and I assume those risks.
- I acknowledge and understand that the Therapist must be fully aware of my existing medical conditions.
- I have completed my medical history form as provided by my Therapist and disclosed to the Therapist all of my medical conditions affecting me.
- It is my responsibility to keep the Massage Therapist updated on my medical history.
- The information I have provided is true and complete to the best of my knowledge.
- I understand that alcohol is not to be consumed before my appointment. If I come to my massage appointment noticeably intoxicated, my therapist will not be able to continue with the appointment and I will be charged for the full session.
- I also understand that within 24 hours of the preexisting appointment if I no-show, cancel, or reschedule there will be a fee of 50% the original appointment fee. Within 2 hours of the appointment the full fee will apply. (exceptions may be granted)
- I have read the above noted consent and I have had the opportunity to question the contents and my therapy.
- I understand the information I have provided on this form is confidential and will not be released without my written consent.
- I understand that I am responsible for any charges incurred in the course of my treatment.
- By signing this form, I confirm my consent to treatment and intend this consent to cover the treatment discussed with me and such additional treatment as proposed by my Therapist from time to time, to deal with my physical condition and for which I have sought treatment.
- I understand that at any time I may withdraw my consent and treatment will be stopped.

Signature _____ Today's date_____

Therapist signature_____ Today's date_____