Massage Therapy Health Information

Client Contact Information

Client Name: ________________________________ Date: ___________

Date of Birth: ___________ Gender: ___________

Address: ____

Phone: ___________________________________ Email: ________________________________

Referred by: ________________________________

Emergency contact: ___________________________ Phone: ________________________________

Physician/Health-care Provider name: ________________________ Phone: __________________

Is this massage/bodywork medically necessary (is it for a medical condition, injury, surgery)? Yes ☐ No ☐

Do you have a physician referral/prescription? Yes ☐ No ☐

Are you seeking insurance reimbursement? Yes ☐ No ☐ If yes, please complete the Billing Information form.

Type of insurance coverage for this claim: Car Collision Worker's Compensation Private Health

Massage Information

Have you ever received professional massage/bodywork before? Yes ☐ No ☐

How recently? ________________________________

What types of massage/bodywork do you prefer? ________________________________

What kind of pressure do you prefer? Light Medium Firm

What are your goals/expected outcomes for receiving massage/bodywork?

____

____

How do you feel today? ____

List and prioritize your current symptoms/issues (stress, pain, stiffness, numbness/tingling, swelling, etc.):

____

____

Do these symptoms interfere with your activities of daily living (e.g., sleep, exercise, work, childcare)? Yes No

Explain:

____

____

List the medications you currently take:

____

____

Are you wearing contacts? Yes ☐ No ☐

Are you wearing dentures? Yes ☐ No ☐

Are you wearing a hairpiece? Yes ☐ No ☐

Are you pregnant? Yes ☐ No ☐

De Premier Spa

281-496-3772

Health Information

Health History

Have you had any injuries or surgeries in the past that may influence today's treatment?

____

Circle any of the following health conditions that you currently have (If you are unsure, please ask):
blood clots, infections, congestive heart failure, contagious diseases, pitted edema
Please answer honestly, as massage may not be indicated for the above conditions.

Please indicate conditions that you have or have had in the past. Explain in detail, including treatment received:

Current Past Muscle or joint pain ______________________________________
Current Past Muscle or joint stiffness ______________________________________
Current Past Numbness or tingling ______________________________________
Current Past Swelling ______________________________________
Current Past Bruise easily ______________________________________
Current Past Sensitive to touch/pressure ______________________________________
Current Past High/Low blood pressure ______________________________________
Current Past Stroke, heart attack ______________________________________
Current Past Varicose veins ______________________________________
Current Past Shortness of breath, asthma ______________________________________
Current Past Cancer ______________________________________
Current Past Neurological (e.g. MS, Parkinson's, chronic pain) ______________________________________
Current Past Epilepsy, seizures ______________________________________
Current Past Headaches, Migraines ______________________________________
Current Past Dizziness, ringing in the ears ______________________________________
Current Past Digestive conditions (e.g. Crohn's, IBS) ______________________________________
Current Past Gas, bloating, constipation ______________________________________
Current Past Kidney disease, infection ______________________________________
Current Past Arthritis (rheumatoid, osteoarthritis) ______________________________________
Current Past Osteoporosis, degenerative spine/disk ______________________________________
Current Past Scoliosis ______________________________________
Current Past Broken bones ______________________________________
Current Past Allergies ______________________________________
Current Past Diabetes ______________________________________
Current Past Endocrine/thyroid conditions ______________________________________
Current Past Depression, anxiety ______________________________________
Current Past Memory Loss, confusion, easily overwhelmed ______________________________________

Comments:

____

____

Consent for Treatment

If I experience any pain or discomfort during this session, I will immediately inform the practitioner so that the pressure and/or strokes may be adjusted to my level of comfort. I further understand that massage/bodywork should not be construed as a substitute for medical examination, diagnosis, or treatment and that I should see a physician, chiropractor, or other qualified medical specialist for any mental or physical ailment of which I am aware. I understand that massage/bodywork practitioners are not qualified to perform spinal or skeletal adjustments, diagnose, prescribe, or treat any physical or mental illness, and that nothing said in the course of the session given should be construed as such. Because massage/bodywork should not be performed under certain medical conditions, I affirm that I have stated all my known medical conditions and answered all questions honestly. I agree to keep the practitioner updated as to any changes in my medical profile and understand that there shall be no liability on the practitioner's part should I fail to do so. I also understand that any illicit or sexually suggestive remarks or advances made by me will result in immediate termination of the session, and I will be liable for payment of the scheduled appointment. Understanding all of this, I give my consent to receive care.

Client Signature: ____ Date: ____________
Parent or Guardian Signature (in case of a minor): ______________________________ Date: ____________