Ethical Massage Tampa
Health History Form

All clients: are required to complete this short, one page, Health History Form prior to their first massage therapy or body work treatment.
Print, fill in this form, and have it available for your appointment.

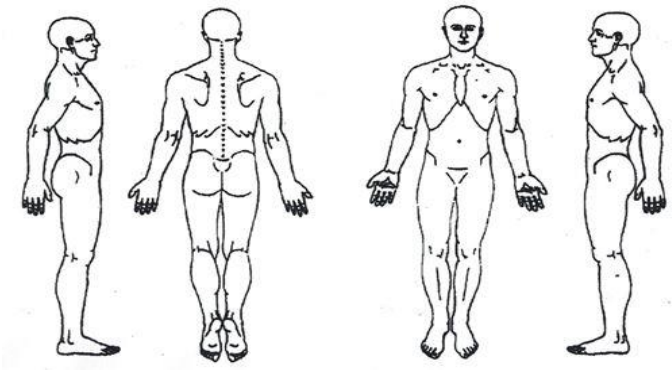
Name: _____
Address: _____Apt#_____
City: _____State_____Zipcode_____Phone Number_____
Email Address: _____
Age: _____DOB_____Weight_____Height_____Occupation_____

What brings you in for a massage? _____
Referred by: _____ Emergency Contact_____ Phone Number_____
Have you ever had a Professional Massage or Structural Integration? Yes_____ No_____ When was your last Professional Massage? _____

Make a Check Mark if you suffer from……pain, numbness, and/or tingling in the following areas listed below.....

Head ___ Neck ___Mid-Back ___Lower-Back ____Hip ____Knee___

Circle any areas of pain



Put a Check Mark…… if you have any of the following health conditions below?

Head/Neck: Headaches__ Epilepsy__ Sinus Infection__ Allergies__ Common Cold__ Vision Problems__ Contacts__ Earaches___ Dry Cough__ Wet Cough__
Respiratory: Smoker__ Shortness of Breath__ COPD__ Asthma__ Sleep Apnea___ Pneumonia__ Covid-19__ Fever/Temp over 100 degrees__ Contagious Viral or Bacterial__
Cardiovascular: High Blood Pressure__ Low Blood Pressure__ Heart Disease__ Poor Circulation__
Muscular/Joints: Stiffness__ Pain__ Swelling__ Limited ROM__ Rheumatoid/Osteo Arthritis___ Scoliosis__ Sciatica__ Disc problems__ Broken Bones___
Skin: Sensitive__ rashes/eruptions__ cold sores__ phlebitis__ bruise easily__ varicose veins___
Digestive: Poor appetite__ Constipation__ Liver/Gallbladder__ Kidney/Bladder__ Difficult Digestion__ Diabetes__ Crohn's Disease__ IBS__ Acid Reflux__ Hiatal Hernia__
Cancer : Yes__ No__ What type? _____Treatment Plan:_____
AIDS or are you HIV Positive: Yes___No___

Surgeries: List and surgeries and dates_____
_____
Accidents/Injuries: List and explain any past accidents/injuries in your life._____
_____
Do you have any pins, wires, artificial joints, or limbs, Wheel Chair, Walker, Cane, or Prosthetic Limbs? Explain_____
_____

Medicines
List all current medications you are taking and the conditions they treat._____
_____

The appointment time I schedule is reserved just for me. If I must reschedule my appointment, I will give at least 24 hours advance notice.
No Shows and Cancellations made less than 24 hours before my scheduled appointment will be charged for the Full session.
At the therapist's sole discretion, exceptions may be made for emergency situations. Client initials_____

Consent for Treatment:
I understand that Massage or Structural Integration 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 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.
Client initials_____

Because massage should not be performed under certain medical conditions, for example contagious viral or bacterial infections (Common Cold, Influenza, Sinus Infection, Bronchitis), or acute cough, excessively runny nose/or fever because these conditions are contraindicated or (disallow) massage therapy treatments. I affirm, I have stated all of 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 I understand that there will be no liability on the practitioner's part should I fail to do so. **Client initials_____**

I also understand that any illicit or sexually suggestive remarks, behaviors, or advances made by me will result in immediate termination of the session and I will be liable for payment of the scheduled appointment in full. Understanding all of this, I give my consent to receive care. **Client initials_____**

Client Signiture_____Date_____
Parent or Guardian Signature (In case of a Minor) _____Date_____