**Lakewood Massage Center**

**Pain, Injury & Deep Tissue Treatment**

**CONFIDENTIAL CLIENT** **HEALTH HISTORY** **INFORMATION FORM**

Please fill out this form completely and to the best of your knowledge.

Today’s Date: \_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_

**Client Information:**

Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Birth date: \_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_

Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Cell Phone: (\_\_\_\_) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

City: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ State: \_\_\_\_\_\_\_ Zip:\_\_\_\_\_\_\_\_\_ Home Phone: (\_\_\_\_) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Occupation: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Employer: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Work Duties: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Emergency Contact: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone: (\_\_\_\_) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Relationship to Client: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Referred By: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

If Billing insurance for medical massage:

Health Insurance:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Policy #:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Subscriber Name & DOB (if not patient):\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**\*I make every effort to remind clients of appointments the day prior; however, in the event I am unable to remind you or your appointment, it is ultimately your responsibility to know your scheduled time. Please indicate how you would like to be reminded:**

\_\_\_ Phone Call: Cell / Home / Work

\_\_\_ Text \_\_\_ No reminder needed

**Healthcare Providers:**

Primary Physician: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone: (\_\_\_\_) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Chiropractor: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone: (\_\_\_\_) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone: (\_\_\_\_) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

I give my massage practitioner permission to consult with my healthcare providers regarding my health and treatment. Comments: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Initials: \_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_

**Massage Preferences:**

Except for the region receiving massage, your body will be covered at all times during your session. The following body regions will not be exposed or touched at any time during your massage session, either by the client or the massage practitioner: Genital areas, breasts, and any areas you are uncomfortable having exposed or touched (please indicate here:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_).

Other massage preferences (i.e. Deep Tissue, Swedish Relaxation, etc.): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Health Information:**

Have you received massage in the past?\_\_\_\_\_\_\_\_\_\_\_ How long ago?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ How often?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ For what purpose?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Why are you seeking massage therapy? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Are you experiencing pain at this time? No / Yes

If yes, explain:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Please list your top 3 areas of concern, and severity of condition(mild, moderate or severe):

1.\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

2.\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

3.\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

List any activities limited by your condition: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Are you suffering from any specific stress at this time? No / Yes: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

How do you reduce stress? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Pain? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Please list any medications you are taking and their purpose: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Please list any additional comments I, as your practitioner, may need to know regarding your health and well-being: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Please check the following conditions that apply to you, and add comments to clarify the condition if applicable.

Past /Present

**Musculo-Skeletal**

□ □ Headaches

□ □ Joint stiffness/swelling

□ □ Spasms/cramps

□ □ Broken/fractured bones

□ □ Strains/sprains

□ □ Back, neck pain

□ □ Shoulder, arm, hand pain

□ □ Hip, leg, foot pain

□ □ Jaw pain/TMJ dysfunction

□ □ Tendonitis

□ □ Bursitis

□ □ Arthritis

□ □ Osteoporosis

□ □ Scoliosis

□ □ Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Past/ Present

**Circulatory and Respiratory**

□ □ Blood clots

□ □ Stroke

□ □ Heart condition

□ □ Allergies

□ □ Sinus problems

□ □ Asthma

□ □ High blood pressure

□ □ Low blood pressure

□ □ Lymphedema

□ □ Other: \_\_\_\_\_\_\_\_\_\_\_\_\_

Past/ Present

**Nervous System**

□ □ Numbness/tingling

□ □ Fatigue

□ □ Chronic pain

□ □ Sleep disorders

□ □ Ulcers

□ □ Spinal cord injury

□ □ Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Past /Present

**Skin**

□ □ Rashes

□ □ Allergies

□ □ Other:\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

***Women:***

Past/ Present

**Reproductive System**

□ □ Pregnancy

How far along? \_\_\_\_\_\_\_\_

□ □ Menopause

□ □ Endometriosis

□ □ Other: \_\_\_\_\_\_\_\_\_\_\_\_\_

Past/ Present

**Other:**

□ □ Depression

□ □ Drug use: \_\_\_\_\_\_\_\_\_

□ □ Alcohol use

□ □ Diabetes:Type\_\_\_\_\_

□ □ Fibromyalgia

□ □ Cancer

□ □ Infectious disease

(please list)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

□ □ Surgeries: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

□ □ Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Informed Client Consent:** (Please initial each section in order to signify that you understand and are in agreement with the statements below.)

**Please read the following information and sign below, indicating your acceptance of these policies:**

\_\_\_\_\_ I understand that this massage is for therapeutic purposes only, and will be completely non-sexual. Any sexual remarks or advances will terminate my session, and I will be liable for full payment of the scheduled session. I also understand that my massage practitioner reserves the right to refuse service for any reason.

\_\_\_\_\_ I have completed this form to the best of my knowledge, and I will inform my massage practitioner of any changes in my health before receiving further massage. I understand that under some health conditions massage may be harmful and therefore agree not to withhold any known information about my health from my massage practitioner. I further agree to allow my massage practitioner to discuss my health with my healthcare provider(s) listed above.

\_\_\_\_\_ I understand that massage practitioners do not diagnose or prescribe for medical illness, disease, or other disorders, and that spinal manipulations are not part of massage therapy. I further understand that massage therapy is not a substitute for medical examination or diagnosis, and that I take responsibility for consulting with my physician for any ailment or condition of concern to me. If I experience any pain or discomfort during the massage session, I will immediately communicate that to the practitioner so that treatment can be adjusted accordingly.

\_\_\_\_\_ I give Lakewood Massage Center permission to bill my insurance company directly. I understand that this is a courtesy, and that I will be responsible for any co-pays, co-insurance, deductibles, or services that are denied or not paid by my insurance company.

\_\_\_\_\_ Unless there is an emergency or inclement weather, I acknowledge that if I am unable to keep a scheduled appointment, 4 hours notice is required or I may be charged for the time reserved. I understand that my session begins promptly at the scheduled time and will end at the scheduled time, regardless if I am late for my appointment. I will be charged for the full scheduled session, even if my massage is shortened due to my tardiness.

\_\_\_\_\_ Federal law requires that a Notice of Privacy Practices be made available to all patients. You have the right to review the Notice and this notice serves as an offer to receive said Notice. Your signature below acknowledges that you have received or have been offered and refused a copy of the Notice.

I have read this form in its entirety, and by signing below I agree to these policies and give my consent to receive massage therapy.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_

Client Signature Date

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Client Printed Name

**If Client is Under Age 18:**

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_

Parent / Guardian Signature (for Clients under Age 18) Date

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Printed Name of Parent / Guardian

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Printed Name of Under-Aged Patient