NATURAL HEALTH CARE CENTER

Promoting Total Health Awareness

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Client Medical History - Massage

Name ______________________________ Date ______________

Reason for Visit ______________________ Occupation ______________

Referred By ______________________ Sex _____ Birthdate ______________

Address ______________________ City/State/Zip ______________

Home Phone ___________ Work Phone ___________ Cell Phone ___________

Family Physician ______________________________

Present Medications ______________________________

Major Operations and Dates ______________________________

Allergies ______________________________

Rate your degree of body flexibility: ☐ Excellent ☐ Good ☐ Fair ☐ Poor
Do you take a daily vitamin/mineral supplement? ☐ Yes ☐ No
Do you experience shortness of breath? ☐ Yes ☐ No
Do you smoke? ☐ Yes ☐ No
If yes, how much? ___________

- ☐ Cysts/Tumors/Cancer
- ☐ High Blood Pressure
- ☐ Bladder Problems
- ☐ Constipation
- ☐ Back Problems
- ☐ Strokes
- ☐ Indigestion
- ☐ Tuberculosis
- ☐ Heart Problems
- ☐ Cold Hands/Feet
- ☐ Water Retention
- ☐ Ulcers
- ☐ Diarrhea
- ☐ Low Blood Pressure
- ☐ Kidney Problems
- ☐ Bruise Easily
- ☐ High Fever
- ☐ Anemia
- ☐ Diabetes

Indicate current problem areas:

Head/Neck	☐ Frequent Headaches	☐ Neck Pains/Tightness	☐ Neck Lumps/Swelling
Digestive	☐ Bloated Stomach	☐ Constipation	☐ Loose Bowels
Skin	☐ Bruise Easily	☐ Open Cuts/Sores	☐ Hypersensitive
Neurological	☐ Difficulty Relaxing	☐ Sleeping Difficulties	
Eyes	☐ Wears Glasses	☐ Wears Contacts	
Respiratory	☐ Breathing Difficulty		

Cardiovascular
☐ High Blood Pressure ☐ Low Blood Pressure ☐ Swollen Feet/Ankles ☐ Leg Cramps

- over -

Musculoskeletal

- ☐ Aching Muscles
- ☐ Aching Joints
- ☐ Lower Back Pain
- ☐ Tennis Elbow
- ☐ Shoulder Pain
- ☐ Painful Feet
- ☐ Carpal Tunnel Syndrome

Indicate diagnosed illnesses (not currently being treated) with a "D" and Indicate illnesses which you are currently undergoing treatment for with a "T".

____ Arthritis/Rheumatism
____ Disease of Bones/Joints
____ Neuritis/Neuralgia
____ Bursitis
____ AIDS*
____ Ulcers
____ Kidney/Bladder Ailment
____ Colitis/Bowel Disorder
____ Diabetes
____ Sciatica
____ CVA/Stroke
____ Tuberculosis
____ Hypertension
____ HIV+
____ Epilepsy

____ Broken Bones(s) - Where?/When? ____________________

____ Sprain/Dislocation - Where?/When? ____________________

____ Cancer/Tumors - Where?/When? ____________________

____ Heart Disease - Where?/When? ____________________

* Note AIDS clients, please note specifice diagnoses and/ or medications which can affect method of therapy:

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For Women Only:

- ☐ Pregnant
- ☐ Lump/Pain in Breasts
- ☐ Cramps

Date of Last Period ____________

Client Agreement

I understand that the massage/bodywork I receive is provided for the basic purpose of relaxation, stress reduction, relief of muscular tension or therapeutic applications. 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 of medical examination, diagnosis or treatment, and that I should see a physician, chiropractor or other qualified medical specialist for any mental or physical ailment that I am aware of.

I understand that massage therapists/bodyworkers are not qualified to perfom spinal or skeletal adjustments, diagnose, prescribe or treat any physical or mental illness, and that nothing said in the course of the session(s) given should be construed as such.

Because massage/bodywork is contraindicated (should not be done) under certain medical conditions, I affirm I have started 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 forget to do so.

It is also understood 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 the "full" scheduled appointment.

Client Signature: ____________________ Date: ____________

Practitioner: ____________________ Date: ____________