naturalbalance
Therapeutic Massage & Wellness Center

Confidential Health History Form

Name:_____ Date of initial visit:_____

Address:_____ City:_____ State:_____ Zip_____

Phone (_____)_____ Work Phone (_____) _____ Cell Phone (_____)_____

The best time to contact me is:_____ ☐ A.M. ☐ P.M. on my ☐ home phone ☐ work phone ☐ cell phone

Date of Birth:_____ Occupation:_____

Name of Physician:_____Phone:_____

Other health care provider:_____

Whom may we thank for referring you? _____

Person to contact in case of emergency_____ Phone_____

Email Address_____

Would you like to receive our e-newsletter? ☐ Yes ☐ No

1. Have you had massage therapy before? ☐ Yes ☐ No
2. For women: Are you pregnant? ☐ Yes ☐ No If yes, how many months?_____
3. Do you have any difficulty laying on your front, back, or side?

   ☐ Yes ☐ No If yes, please identify_____
4. Do you have allergic reactions to oils, lotions, ointments, liniments, or other substances put on your skin?

   ☐ Yes ☐ No If yes, please identify_____
5. Do you wear: ☐ contact lenses, ☐ dentures, or ☐ hearing aids
6. Do you sit for long hours at a work station, computer, or driving?

   ☐ Yes ☐ No If yes, please identify_____
7. Do you perform any repetitive movement in your work, sports, or hobbies?

   ☐ Yes ☐ No If yes, please identify_____

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8. Do you experience stress in your work, family, or other aspect of your life? ☐ Yes ☐ No

How would you describe your stress level? ☐ Low ☐ Medium ☐ High ☐ Very high

If high, how do you think stress has impacted your health?_____

muscle tension ☐ anxiety ☐ insomnia ☐ irritability ☐ other_____

9. Is there a particular area of the body where you are experiencing tension, stiffness, or other discomfort?

☐ Yes ☐ No If yes, please identify_____

Medical History

In order to plan a massage session that is safe and effective, we need some general information about your medical history.

10. Are you currently under medical supervision? ☐ Yes ☐ No If yes, please identify_____

11. Are you currently taking any medications? ☐ Yes ☐ No If yes, please identify_____

Please check any condition listed below that applies to you:

- ☐ Skin condition (e.g., acne, rash, skin cancer, allergy, easy bruising, contagious condition)
- ☐ Allergies
- ☐ Past accident, injury, or surgery (e.g., whiplash, sprain, broken bone, deep bruise)
- ☐ Muscular problems (e.g., tension, cramping, chronic soreness)
- ☐ Joint problems (e.g., osteoarthritis, rheumatoid arthritis, gout, hypermobile joints, recent dislocation)
- ☐ Lymphatic condition (e.g., swollen glands, nodes removed, lymphoma, lymphedema)
- ☐ or blood conditions (e.g., atherosclerosis, varicose veins, phlebitis, arrhythmias, high or low blood pressure, heart disease, recent heart attack or stroke, blood clots, anemia)
- ☐ Neurologic condition (e.g., numbness or tingling in any area of the body, sciatica, damage from stroke, epilepsy, multiple sclerosis, cerebral palsy)
- ☐ Digestive conditions (e.g., ulcers)
- ☐ Immune system conditions (e.g., chronic fatigue, HIV/AIDS)
- ☐ Skeletal conditions (e.g., osteoporosis, bone cancer, spinal injury)
- ☐ Headaches (e.g., tension, PMS, migraines)
- ☐ Cancer
- ☐ Emotional difficulties (e.g., depression, anxiety, panic attacks, eating disorder, psychotic episodes). Are you currently seeing a psychotherapist for this condition? ☐ Yes ☐ No
- ☐ Previous surgery, disease, or other medical condition that may be affecting you now (e.g., polio, previous heart attack or stroke, previously broken bones, abdominal aortic aneurysm)
- ☐ Elective surgery or procedures

Comments:_____

_____

_____

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14. Is there anything else about your health history that you think would be useful for your massage practitioner to know to plan a safe and effective massage session for you?

_____

_____

_____

15. Has your physician or other health care provider recommended massage for any of the conditions listed above? ☐ Yes ☐ No

If yes, please explain_____

16. Do you have any particular goals in mind for this massage session related to any of the conditions mentioned above? ☐ Yes ☐ No

If yes, please explain_____

I understand that I should see a doctor or other appropriate health care provider for diagnosis and treatment of any suspected medical problem. It may be beneficial for my massage practitioner to speak to my doctor about my medical condition to determine how massage may help the healing process, and to avoid worsening the condition. I will be asked for permission to contact my doctor, if the massage practitioner thinks that it might be useful. I also understand that it is my responsibility to keep my massage practitioner informed of any changes in my health, and any medications that I may begin to take in the future.

Signature_____Date_____

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General Agreement and Consent

I, _____ understand that the massage therapy given to me by Danielle Honan is for the purpose of general health and wellness, relaxation, improved circulation, pain management, and other effects supported by experience and research. Massage therapy is performed here within the scope of practice of massage therapists in this state.

I understand that massage therapists do not diagnose medical conditions, nor do they prescribe medical treatments or medications, nor do they perform spinal manipulation or chiropractic adjustments.

I understand that massage therapy is not a substitute for examination by a medical provider, and that it is recommended that I seek medical attention first for any illness, injury, or disorder that I might have.

I understand that massage therapy can be a valuable complement to health care provided by medical doctors, chiropractic physicians, naturopathic physicians, practitioners of traditional Chinese medicine, and psychiatrists and psychologists. I agree to keep my massage therapist informed of any medical treatment I am receiving with the understanding that it may impact the massage therapy I receive.

I have stated all my known medical conditions, treatments, and medications, and I agree to keep the massage therapist updated on any changes.

My signature below confirms my agreement to the general policies, privacy policy, and consent statements above.

Name _____ Date_____

Witness _____ Date_____