hARTS+HANDS Therapeutic Massage Center
Client Health Questionnaire

First Name:________________________________ Last Name:__________________________________

Date of Birth:_____/_____/_____

Email:____________________________ Home Ph:_____________________ Cell Ph:_______________________

Address:____

City:______________________ State:______________ Zip:____________

Referred by:________________________

Emergency Contact Name:_________________________ Relationship:______________________

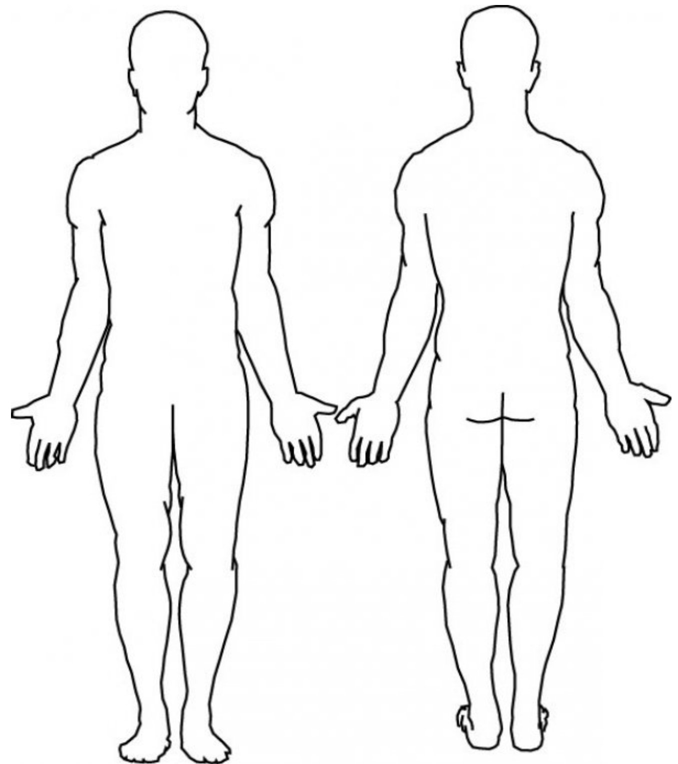
Phone:_____________________

Physician Name:____________________ Phone:_______________________

Primary Complaint

(Briefly describe the problems you've been experiencing in the space provided and circle the location[s] on the images below.)

Please explain:



How long since you first became aware of these issues?

____

Past Treatments:____

Have you ever had a professional massage befo
re? __________

If yes then how long ago?_________________________________

Are you right-handed or left-handed?_______________________

Do you prefer light, medium, or firm pressure?_______________

Do you have any areas that you prefer not to be worked on?

Example: face, abdomen, feet________________________

Existing Conditions

(please check all that apply)

Respiratory:

❑ N/A

❑ Shortness of Breath ❑ Emphysema ❑ Chronic Cough

❑ Asthma ❑ Other:_______________

Cardiac:

❑ High/Low Blood Pressure ❑ History of Stroke

❑ N/A

❑ Heart Attack ❑ Blood Clots/Thrombosis/Embolism ❑ History of Heart Attack

❑ Other:____________________

Skin:

❑ Sensitive Skin ❑ Melanoma ❑ Bruise easily

❑ N/A ❑ Urticaria/Hives ❑ Psoriasis ❑ Spider Veins/ Varicose Veins

❑ Eczema/Dermatitis ❑ Other:________________

Head & Neck:

❑ Migraines ❑ Headaches ❑ Jaw Pain (TMJD)

❑ N/A ❑ Hearing Loss ❑ Dizziness ❑ Vision Problems/ Vision Loss

❑ Sinus Problems/ Congestion ❑ Ear Problems ❑ Other:______________

Infectious:

❑ Hepatitis ❑ Pneumonia/Bronchitis/Strep

❑ N/A ❑ Cold/Flu ❑ HIV

❑ Athlete's Foot/other fungal infection ❑ Herpes ❑ other:__________

Female Conditions:

- ❑ N/A
- ❑ Pregnant
  If yes, how many weeks? _______
- ❑ Other: _______________

Miscellaneous:

- ❑ N/A
- ❑ allergies
- ❑ Insomnia
- ❑ Osteoarthritis
- ❑ Loss of Sensation
- ❑ Osteoporosis
- ❑ Gout
- ❑ Arthritis
- ❑ Rheumatoid Arthritis
- ❑ Cancer
- ❑ Diabetes
- ❑ Fibromyalgia
- ❑ Other:________________

Medications

(Please list any medications or drugs you are currently taking.)

Client Waiver form

Please take a moment to read and initial the following information.

____ I understand that massage therapy is provided for stress reduction, relaxation, relief from muscular tension, and improvement of circulation and energy flow.

____ If I experience pain or discomfort during the session, I will immediately inform my therapist so that pressure/strokes can be adjusted to my level of comfort. I will not hold my therapist responsible for any pain or discomfort I experience during or after the session.

____ I understand that the services offered today are not a substitute for medical care. I understand that my therapist is not qualified to perform spinal or skeletal adjustments, diagnose, prescribe, or treat physical or mental illness.

____ I affirm that I have notified my therapist of all known medical conditions and injuries.

____ I agree to inform the therapist of any changes in my health and medical condition.
I understand that there shall be no liability on the therapist's part should I forget to do so.

____ I understand that massage is entirely therapeutic and non-sexual in nature.

____ By signing this release, I hereby waive and release my therapist from any and all liability, past, present, and future relating to massage therapy and bodywork.

I have read the statement above and agree to all the policies therein.

Client Signature____________________________________ Date__________________