Mountain Massage Client Health History

This history is confidential. The information will help to determine if therapeutic massage is indicated and which procedures are appropriate.

Date_____ Referred by_____

Client Contact Information

Client name_____ Birthdate_____

Street address_____

City_____ State_____ Zip code_____

Phone (_____)- _____ Email_____

Contact preference(s) ___ Call ___Text ___Email Occupation_____

Please check all that apply

- ☐ Allergies -list below
- ☐ Arthritis/Rheumatism
- ☐ Asthma/breathing problems
- ☐ Athlete's foot/Fungal infections
- ☐ Back pain (upper/mid/low)
- ☐ Birth trauma
- ☐ Blood clots/Phlebitis
- ☐ Broken bones – list below
- ☐ Bruise easily
- ☐ Bursitis
- ☐ Cancer/tumors -list below
- ☐ Carpal tunnel syndrome
- ☐ Chronic fatigue
- ☐ Contact lenses
- ☐ Dermatitis/Eczema/Psoriasis
- ☐ Diabetes
- ☐ Digestive problems/Acid reflux/IBS
- ☐ Disk problems (slipped/herniated/bulging)
- ☐ Dizziness
- ☐ Emphysema
- ☐ Epilepsy/Seizures
- ☐ Fibromyalgia
- ☐ Chronic headaches
- ☐ Heart Disease – list below
- ☐ Hepatitis
- ☐ High/Low Blood Pressure (controlled yes / no)
- ☐ HIV/AIDS
- ☐ Implants – list below
- ☐ Infection/Inflammation/fever
- ☐ Kidney/bladder/prostate
- ☐ Lupus Erythematosus
- ☐ Lymphedema
- ☐ Migraine headaches
- ☐ Neck pain
- ☐ Orthopedic pins or plates
- ☐ Osteoporosis
- ☐ Plantar fasciitis
- ☐ PMS/Menopause problems
- ☐ Pregnant/Trying
- ☐ Poor circulation
- ☐ Ringing in the ears
- ☐ Sciatic pain
- ☐ Sinusitis
- ☐ Skin rashes
- ☐ Sprains/Dislocations – list
- ☐ Stiff neck
- ☐ Stress/Anxiety/Depression
- ☐ Stroke – Date_____
- ☐ Surgeries – list below
- ☐ Survivor of abuse/trauma
- ☐ TMJ
- ☐ Ulcer/colitis/diverticulitis
- ☐ Varicose veins
- ☐ Whiplash
- ☐ Have received professional massage before today. Last massage date_____

Please explain items checked above (with dates) _____

_____

Any physical activities that cause you a problem_____

Trouble lying in any position? _____

Medications/Supplements: Name _____ Purpose _____

Name _____ Purpose _____

Name _____ Purpose _____

Name _____ Purpose _____

Physician _____ Phone _____

Chiropractor/Physical therapist _____ Phone _____

Emergency contact _____ Phone_____

Your general goal for massage therapy _____

IN A PROFESSIONAL MASSAGE, YOUR RIGHTS AS A CLIENT INCLUDE:

- The right to **feel comfortable** and **control the amount of clothing removed for the session**
- The right to **control the areas of your body to be touched**
- The right to be **draped at all times,** and to **feel secure with the draping technique**
- The right to **control the amount of pressure applied** in any area of your body
- The right to have **compete privacy** while dressing and undressing
- The **right to talk or not talk** during the session, and to share or not share your internal experiences during the session.
- The right to **be listened to carefully,** and **be treated with respect**, verbally and non-verbally
- The right to **terminate the session at any time**

Because massage/bodywork should not be performed under certain medical conditions, I affirm I have stated all my known medical conditions, and answered all questions honestly. I will keep my massage therapist aware of any changes to my medical profile, and understand there shall be no liability of the part of the therapist if I fail to do so. If my medical condition requires it, I understand I may be required to receive medical clearance from my primary care provider before receiving massage.

Every person brings his or her own history in a massage session. I agree to inform my therapist is touch in any area is uncomfortable for me, needs to be modified to be comfortable, or need to be avoided for the current session (or any number of sessions). I will also inform my therapist of any changes to me mental or emotional state of being which may influence the choice of modalities to be used or the areas to be worked, for the purpose of enhancing my sense of safety, and my potential holistic benefits from the work.

I will immediately inform the therapist if I experience any pain or discomfort during the session.

I understand that a practitioner's touch and the manner of communication between, therapist and client are never intended to be sexual in nature. I agree to immediately inform the therapist if I feel the manner of touch or language feels sexual or inappropriate **to me**, so the session may be stopped or changed. I understand that any illicit or sexually suggestive remarks to advances made by me, the client, are grounds for immediate termination of the session, and I, the client, will still be liable for payment of the full cost of the scheduled appointment.

I understand that massage therapy is not a substitute for medical examination, diagnosis or treatment. I also understand that the massage/bodywork I receive is for the basic purpose of relaxation, relief of muscular tension, stimulation of the circulatory and lymphatic systems, and craniosacral balance.

I understand that massage therapists are not primary care providers, and any information provided by them is for educational purposes, and should not be taken as medical advice or counseling. If I require medical advice or counseling, I understand I should consult a physician, chiropractor, or other health care practitioner.

I understand my client information is maintained incompliance with federal privacy laws.

Client signature_____ Date _____

Therapist signature _____ Date _____