HAND & STONE® MASSAGE AND FACIAL SPA

MASSAGE THERAPY CLIENT HEALTH HISTORY FORM

Last Updated: _____

The information requested below will assist us in treating you safely. Feel free to ask any questions about the information being requested. Please note that all information provided below will be kept confidentially unless allowed or required by law. Your written permission will be required to release any information. Clinical notes for your appointment entered by your Therapist will be available for our other therapists in order to ensure you are provided with the appropriate treatment at each appointment.

Name:	Phone #:
Home Address:	Email Address:
Occupation:	Date of Birth:
Emergency Contact (mandatory) Name: Phone#:	Primary Care Physician: Address:
How did you hear about us?	Are you currently receiving treatment from another health care professional? ☐ YES ☐ NO If YES, for what?

Please indicate conditions you are experiencing or have experienced:

Cardiovascular:
- ☐ High blood pressure
- ☐ Low blood pressure
- ☐ Chronic congestive heart failure
- ☐ Heart attack
- ☐ Phlebitis/varicose veins
- ☐ Stroke/CVA
- ☐ Pacemaker or similar device
- ☐ Heart disease

Is there a family history of any of the above?
☐ YES ☐ NO

Respiratory:
- ☐ Chronic cough
- ☐ Shortness of breath
- ☐ Bronchitis
- ☐ Asthma
- ☐ Emphysema

Is there a family history of any of the above?
☐ YES ☐ NO

Infections:
- ☐ Hepatitis
- ☐ Skin conditions
- ☐ TB
- ☐ HIV
- ☐ Herpes

Other Conditions:
- ☐ Loss of sensation, where?
- ☐ Diabetes, onset:
- ☐ Epilepsy
- ☐ Cancer, where?
- ☐ Skin conditions, what?
- ☐ Arthritis, where?
- ☐ Allergies/Hyper sensitivity to what?
  Type of reaction:

Is there a family history of any of the above?
☐ YES ☐ NO

Do you have any other medical conditions? (e.g. digestive conditions, haemophilia, osteoporosis, mental illness): ☐ YES ☐ NO
Please Specify:

Head/Neck:
- ☐ History of headaches
- ☐ History of migraines
- ☐ Vision problems
- ☐ Vision loss
- ☐ Ear problems
- ☐ Hearing loss

Women:
- ☐ Pregnant, due:
- ☐ Gynecological conditions, what?

Overall, how is your general health?

Do you have any internal pins, wires, artificial joints or special equipment? ☐ YES ☐ NO
What: Where:

Current medications: Condition it treats:	Are you currently taking: ☐ Antibiotics ☐ Blood thinners ☐ N/A ☐ Birth control ☐ Hormone replacement
Please list any surgeries or injuries: Surgery – date: Nature: Injury – date: Nature:	

MASSAGE

Have you received massage therapy before? ☐ YES ☐ NO	What is the reason you are seeking massage therapy? Please include the location of any tissue or joint discomfort or area of focus.
Did a health care practitioner refer you for massage therapy? ☐ YES ☐ NO If yes, please provide their name and address:	

Please Turn Over

Consent: I understand that the **massage therapy treatment** I receive is provided for the purpose of relaxation and relief of muscular tension. If I experience any pain or discomfort during the session, I will immediately inform the Massage Therapist so that the pressure and/or strokes may be adjusted to my level of comfort. I further understand that massage therapy is not a substitute for medical examination, diagnosis or treatment and that I should see a physician or qualified medical specialist for any physical or medical ailment of which I am aware. I understand massage therapy should not be performed under certain medical conditions, and I affirm that I have stated all my known medical conditions and have answered all questions accurately.

I understand that I may disrobe to my comfort level. I acknowledge that it is my choice of a female or male massage therapist and that I may stop or rescind my consent at any time if I am in any way uncomfortable. Initial Here: _____

I understand that HAND & STONE MASSAGE AND FACIAL SPA reserves the right to refuse to administer services at their sole discretion. I have read and fully understand this form in its entirety. If at any time there are changes in the information given, or in my condition, I will notify my service provider, and update this form before receiving additional services. I have read and fully understand this form in its entirety. I hereby release the Massage Therapists, HAND & STONE MASSAGE AND FACIAL SPA and their insurers, and their respective officers, directors, stockholders, successors, employees, franchisor and agents from all liability of any nature whatsoever, whether past, present, or future, for injury or damage which may occur to myself or my family as a result of my receiving massage therapy.

If I am unable to make a scheduled appointment, I agree to cancel the appointment 24 hours in advance by phone, unless I have an emergency. In this case I will call ASAP to reschedule my appointment. If I miss a scheduled appointment without giving 24-hour notice, I agree to pay the missed appointment fee that applies. Initial Here: _____

My signature below affirms that I have read, agree to the foregoing and the information I have provided is accurate and true.

SIGNATURE: _____ **DATE:** _____

Consent to treatment of minor: By my signature below, I authorize HAND & STONE MASSAGE AND FACIAL SPA to administer massage therapy to my minor child or dependent (name: _____) as they deem necessary or proper.

SIGNATURE: _____ **DATE:** _____