Shine Sparrow
THERAPY

HEALTH HISTORY FORM

Name _____ Today's Date ____/____/____
Address _____ Gender Identity _____
City / State / Zip _____ Date of Birth ____/____/____
Phone Contact _____ Email _____
Emergency Contact _____ EC # _____
Referred by _____ Have you ever received a massage therapy treatment? Y / N
Reason for your massage therapy appointment today _____
_____

MEDICAL HISTORY

Are you currently being treated under care of a physician? Y / N Date of last physical exam _____
Physician _____ Phone Number _____
Are you pregnant? Y / N If yes, what week? _____
List any current diagnosis and treatment you are receiving _____
List present medications and for what conditions _____
List dietary and herbal supplements, vitamins, or homeopathic remedies _____
_____
List any major surgery and date/year _____
List any broken bones or sprains with location _____
List any joint replacement(s) with location _____
List any skin conditions _____ Do you bruise easily? Y / N
List any allergies _____ To lotions Y / N To scents Y / N
List any contagious condition(s) _____

DAILY HEALTH HABITS

Rate your current stress level High Moderate Low Minimum
Occupation _____ Physical Activities _____

Circle your most frequent body position(s)

Standing	Sitting	Stooping	Lifting	Bending
Leaning Forward	Kneeling	Head held long hours in abnormal position		Repetitive movement

Specify _____

Rate your degree of body flexibility Excellent Good Fair Poor

Other _____

Circle areas of concern
Musculoskeletal

Aching muscles	Aching joints	Neck pain	Tension Headaches	Shoulder Pain
Wrist/elbow	Mid-back pain	Low back pain	Hip pain	Knee ankle pain

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Neurological	Sharp/shooting sensation	Numbness	Neuritis or Neuralgia
	Difficulty sleeping	Difficulty relaxing	Other
Cardiovascular	High blood pressure	Low blood pressure	Swollen feet or ankles
	Varicose veins	Cold hands/feet	Cerebral vascular attack or stroke

When _____ Other _____

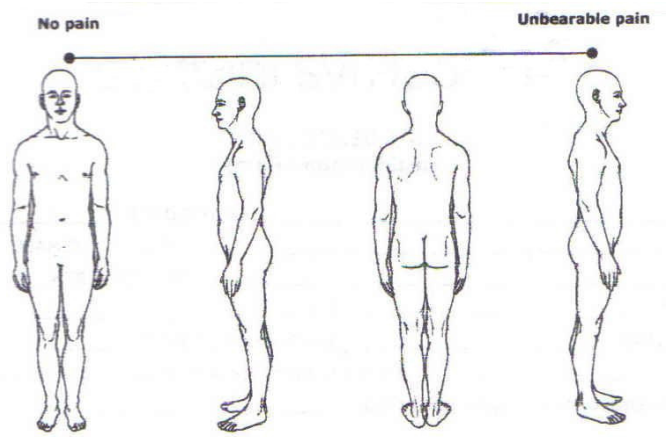
Digestive	Indigestion/Bloated stomach	Constipation	Loose bowels/diarrhea
	Ulcers	Bladder problems	Kidney problems
Genitourinary	Other _____		

Females: If you are currently on your menses, are you experiencing any breast or abdominal discomfort? Y / N

Endocrine Diabetic Other _____

Do you have any other medical condition not listed? _____

Please circle or place an "x" on any areas of discomfort or pain. Rate your current pain level:



I understand that the massage/bodywork I receive is provided for the basic purpose of relaxation and relief of muscular tension. 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 or bodywork should not be construed as a substitute for medical examination, diagnosis, or treatment and that I should see a physician, chiropractor, or other qualified medical specialist for any mental or physical ailment of which I am aware. I understand that massage/bodywork practitioners are not qualified to perform spinal or skeletal adjustments, diagnose, prescribe, or treat any physical or mental illness, and that nothing said in the course of the session given should be construed as such. Because massage/bodywork should not be performed under certain medical conditions, I affirm that I have stated 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 fail to do so. I also understand 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 payment of the scheduled appointment. I understand it is my responsibility to cancel 24 hours in advance to avoid paying a cancellation fee.

Client Signature _____ Date _____

Practitioner Signature _____ Date _____