

BODYWISE THERAPY

CLIENT HEALTH HISTORY

Name _____ Date _____ Birthdate _____
Address _____ City _____ State _____ Zip _____
Home Phone _____ Cell/Work Phone _____ E-mail _____
Occupation _____ Work Responsibilities _____
Emergency Contact _____ Relationship _____ Phone _____

CURRENT HEALTH

Have you ever received massage therapy before? Yes No Frequency: _____

Desired pressure: Light Medium Firm Deep

Reason for today's visit: _____

Classify concern: Minor Problematic Major

Classify type: Recurring Getting worse Getting better

Desired result/goal of today's session: _____

Have you received treatment for this before Yes No Explain: _____

List activities affected: _____

Current medication (Rx, OTC, herbal, etc): _____

Exercise activities: _____ Frequency: _____

Check any of the following that apply to your current health:

Pregnancy Heart Conditions Circulatory Conditions Blood Clots Cancer

Diabetes Infections Difficulty Breathing Arthritis Tense Muscles

HIV/AIDS Allergies (list below) Low/High Blood Pressure (circle type) Spinal Injury

Other _____

Other concerns you may have: _____

MEDICAL HISTORY

(list in chronological order; give dates or ages and treatment received)

Surgeries: _____

Accidents: _____

Major Illnesses: _____

CONSENT FOR CARE

It is my choice to receive massage therapy, I am aware of the benefits and risks of massage and give my consent for massage. I understand that breast massage will at no time be a part of my therapy. I also understand that the effectiveness of individual techniques or series of appointments may vary. I acknowledge that massage therapy is not a substitute for medical care, medical examination, or diagnosis. I have stated all of my known medical conditions and will inform my therapist of any changes in my health status.

Client's Signature _____ Date _____

Therapist's Signature _____ Date _____

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CLIENT ASSESSMENT FORM

To ensure that your time in therapy meets your specific needs, the following information will assist you and your therapist in achieving open communication and understanding about massage therapy.

Your therapy today may include the head, face and neck, as well as the arms, legs, and back. Please take a moment to mark on the figures all areas of:

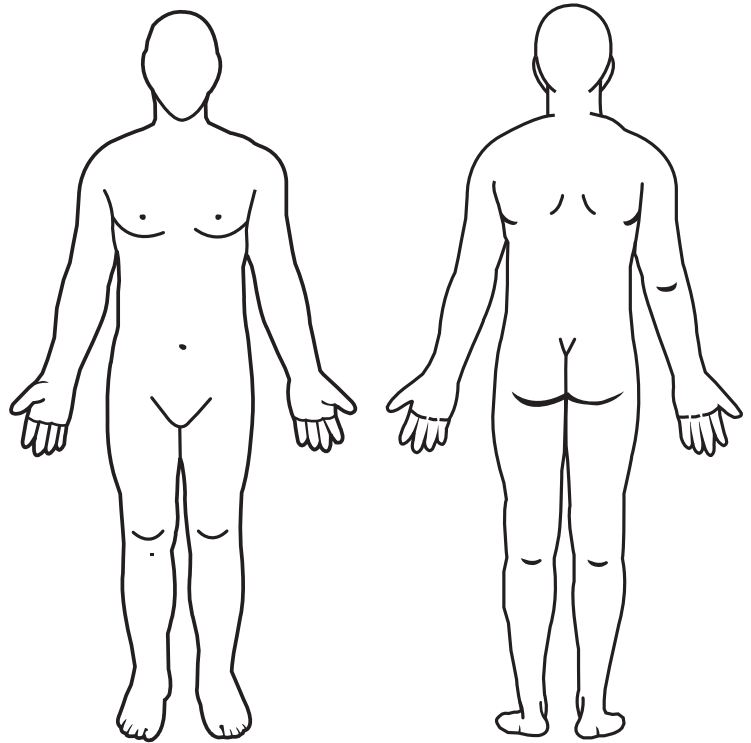
Pain and/or tenderness with X's

Numbness and/or tingling with Z's

Swelling and/or stiffness with O's

Scars, bruises, and/or open wounds with S's

THERAPIST'S NOTES:



- Massage therapy in general is given to relieve stress and/or muscular tension, to enhance circulation and digestion, and to promote overall well-being
- Massage is not be used in place of medical treatment
- The preceding health history is accurate and not withholding any medical needs or conditions
- Any areas of concern regarding your health will be respected by the therapist during the session
- If for any reason you become uncomfortable during the session, you may ask the therapist to cease the massage session
- If any health issues or modifications occur before future appointments, it is your responsibility to inform your therapist of such changes
- **NO-SHOWS FOR SCHEDULED APPOINTMENTS, AND CANCELLATIONS WITHOUT 24 HOURS NOTICE WILL STILL INCUR THE FULL PRICE OF THE APPOINTMENT.**

Client's Signature _____ Date _____

Therapist's Signature _____ Date _____