

# HEALTH HISTORY FORM

## ISLAND FITNESS CANCELLATION POLICY

If you need to cancel your massage appointment, please do so 24 hours before your appointment. Appointments cancelled with less than 24 hours' notice will be billed at the full price of the missed massage. Billing of cancellations with less than 24 hours' notice due to illness or an emergency will be left to the discretion of the therapist. By signing this, you acknowledge our cancellation policy and agree to its terms.

SIGNATURE \_\_\_\_\_

DATE \_\_\_\_\_

## PERSONAL DATA

Name \_\_\_\_\_

Date of Birth \_\_\_\_\_ referred by \_\_\_\_\_

Address \_\_\_\_\_

City \_\_\_\_\_

State \_\_\_\_\_ Zip \_\_\_\_\_

Phone Home / Cell \_\_\_\_\_

Phone Work / Cell \_\_\_\_\_

Occupation \_\_\_\_\_

Emergency contact \_\_\_\_\_

Phone \_\_\_\_\_

Primary health care provider \_\_\_\_\_

Location \_\_\_\_\_

Phone \_\_\_\_\_

Do you currently train?  YES  NO

Name of trainer \_\_\_\_\_

Location \_\_\_\_\_

Phone \_\_\_\_\_

What are your goals for receiving massage therapy? \_\_\_\_\_

*"I give my massage therapist permission to contact and/or consult with my health care provider(s) and trainer(s) regarding my health and treatment."*

INITIALS \_\_\_\_\_

DATE \_\_\_\_\_

## LIST SELF-CARE ROUTINES

How do you reduce stress? \_\_\_\_\_

Pain? \_\_\_\_\_

Have you ever received massage therapy before?

YES  NO IF YES, FREQUENCY? \_\_\_\_\_

## HEALTH INFORMATION

Health concerns. Check all that apply:

PRIMARY CONCERN \_\_\_\_\_

mild  moderate  disabling

symptoms increase with activity  symptoms decrease with activity

intermittent  constant

getting better  getting worse  no change

treatment received \_\_\_\_\_

SECONDARY CONCERN \_\_\_\_\_

mild  moderate  disabling

symptoms increase with activity  symptoms decrease with activity

intermittent  constant

getting better  getting worse  no change

treatment received \_\_\_\_\_

## LIST DAILY ACTIVITIES LIMITED BY CONDITION

Work \_\_\_\_\_

Home/family \_\_\_\_\_

Sleep/self-care \_\_\_\_\_

Social/recreational \_\_\_\_\_

## HEALTH HISTORY

List and explain. Where appropriate, include dates or general time frame and treatment(s) received.

MEDICATIONS \_\_\_\_\_

ALLERGIES \_\_\_\_\_

SURGERIES \_\_\_\_\_

MAJOR ILLNESSES \_\_\_\_\_

INJURIES/ACCIDENTS \_\_\_\_\_

PLEASE FILL OUT REVERSE >

FIRST NAME

LAST NAME



