HEALTH HISTORY FORM

FIRST NAME

LAST NAME

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 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 ____________________

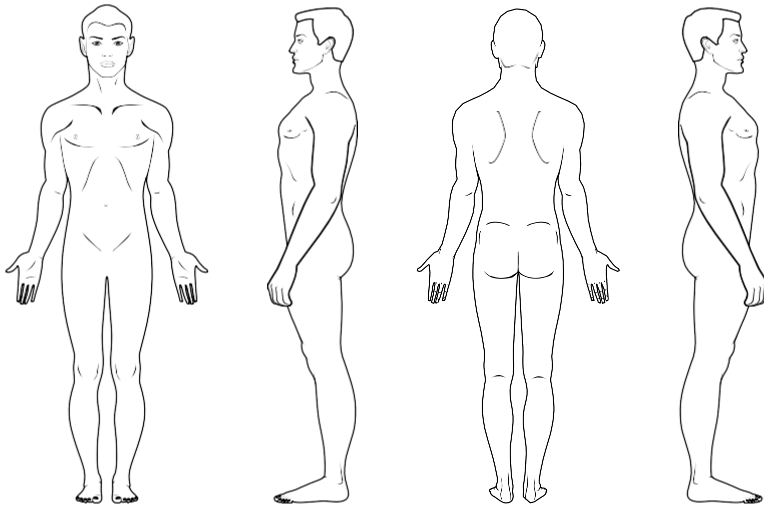
SURGERIES ____________________

MAJOR ILLNESSES ____________________

INJURIES/ACCIDENTS ____________________

Please Fill out reverse >

INDICATE AREAS WHERE YOU ARE EXPERIENCING SYMPTOMS ON THE FIGURES



Prioritize the areas of your body that you would prefer to be massaged. Mark with 1, 2, 3, etc., or "I would like full body massage, with attention paid to:" __

____
____
____
____
____

For which area(s) of your body do you give permission to receive massage? Check all that apply:

- ☐ back ☐ legs ☐ buttocks ☐ arms
- ☐ abdomen ☐ chest ☐ neck ☐ head
- ☐ face ☐ other ______________________________

It is my choice to receive massage therapy. I realize that the treatment is being given for the well-being of my body and mind. This includes stress reduction, relief from muscular tension, spasm, or pain, or for the increasing circulation or energy flow. I agree to communicate with my practitioner any time I feel like my well-being is being compromised.

I understand that massage practitioners do not diagnose illness, disease, or any physical or mental disorder; nor do they prescribe medical treatment, pharmaceuticals, or perform spinal thrust manipulations. I acknowledge that massage is not a substitute for medical examination or diagnosis, and that it is recommended that I see a primary health care provider for that service.

I have stated all medical conditions that I am aware of and will update the massage practitioner of any changes in my health status.

____
SIGNATURE DATE

FOR THERAPIST USE ONLY

REVIEWED BY CLIENT ______________________________
initial *date*

NOTES:

Island Fitness Cancelation Policy

*Cancel 48 hrs or more before your session = early cancel/no charge

*Cancel 24 to 48 hrs before your session - you will be charged 50% of the session fee

*Cancel 24 hrs or less before your session - you will be charged the full session fee

Cancelations due to emergency or unexpected illness will be left to the discretion of the Department Manager.

By signing this, you acknowledge and agree to the cancelation policy.

____
SIGNATURE DATE