Elemental Health LLC

Massage Therapy and Bodywork Medical History Form

Name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

City \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Zip Code \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Phone \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Email \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

What brings you to massage therapy at this time?

What do you hope to accomplish through massage therapy?

Have you had a professional massage before?

How frequently?

What did you like about your prior experiences?

What did you dislike about your prior experiences?

Please circle any of the following that apply :

**Musculoskeletal:**

Bone or joint disease

Tendonitis/bursitis

Jaw pain/tmj

Spinal problems

Migraines

headaches

**Circulatory Concerns**

Heart conditions

Varicose Veins

History of blood clots

Blood pressure low/high

**Respiratory Conditions**

Breathing difficulty

Sinus Problems

Sleep apnea

**Nervous System**

Shingles

Numbness/Tingling

Pinched Nerves

Chronic pain

MS

Parkinson’s Disease

**Skin**

Allergies

Rashes

Athlete’s foot

Cosmetic surgery

**Digestion**

Irritable Bowel Syndrome

Crohn’s disease

Bladder/Kidney ailments

Ulcers

**Psychological**

Anxiety

Stress

Depression

Mental ‘fogginess’/fatigue

insomnia

**Other**

**Lifestyle**

How often do you exercise:

Daily 4-5 x per week 2-3 times per week

Weekly 2 x per month once per month

Please describe your exercise activities

How much water do you drink per day?

***Please indicate on the drawings where you have had surgeries, chronic pain, or areas of concern for massage therapy***



***Client Agreement for Treatment:***

*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 there is no implied or stated guarantee of success of effectiveness of individual techniques or series of appointments. I acknowledge that massage therapy is not a substitute for medical care, medical examination or diagnosis. I have stated all medical conditions that I am aware of and will inform my practitioner of any changes in my health status.*

*I commit to open discussion with Elemental Health practitioners regarding any concerns I have during or following treatment.*

*I agree to pay the disclosed amount of treatment at the time services are rendered. I agree to pay for missed scheduled appointments if I should have to cancel with less than 24 hours of notice.*

*Signed:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_*