Colorado Advanced Massage
Health History Form

So that you may be better served, please respond to the questions that pertain to you by printing clearly. This is part of your client file, and is considered confidential.

Please check all of the following conditions that currently apply to you:

- ☐ Acute Infection
- ☐ Acute Injury
- ☐ Allergies
- ☐ Arthritis
- ☐ Artificial Joint
- ☐ Asthma
- ☐ Atherosclerosis
- ☐ Autoimmune Disorder
- ☐ Athlete's Foot
- ☐ Bruising/Bruise easily
- ☐ Cancer
- ☐ Carpal Tunnel Syndrome
- ☐ Cold/Flu
- ☐ Colitis
- ☐ COPD
- ☐ Chronic Back Pain
- ☐ Chronic Cough
- ☐ Crohn's Disease
- ☐ Chronic Fatigue
- ☐ Depression
- ☐ Diabetes

  __ insulin dependent?

- ☐ Digestive Concerns
- ☐ Dizziness
- ☐ Eczema
- ☐ Edema
- ☐ Epilepsy/Seizures /Convulsions
- ☐ Fatigue
- ☐ Fever
- ☐ Fibromyalgia
- ☐ Headaches
- ☐ Hearing problems/loss
- ☐ Heart Condition
- ☐ Hepatitis
- ☐ Herniated Disc
- ☐ High Blood Pressure
- ☐ HIV/AIDS
- ☐ IBS
- ☐ Infectious Condition
- ☐ Insomnia
- ☐ Leg cramps
- ☐ Loss of Range of Motion
- ☐ Loss of sensation

Basic Information:

Name_____Date of Birth / /_____

Address_____

City_____State_____Zip _____

Phone-Best two #'s for contact: H/W/C_____H/W/C _____

E-mail address _____

Occupation/Employer_____Referred by _____

The following information will be used to help plan safe and effective massage sessions. Please answer the questions to the best of your knowledge.

1. Do you have any difficulty lying on your front, back, or side? Yes No
2. Do you have any allergies to oils, lotions, nuts, or flowers? Yes No
3. Do you sit for long hours at a workstation, computer, or driving? Yes No
4. Do you perform any repetitive movement in your work, sports, or hobby? Yes No
5. Is there a particular area of the body where you are experiencing tension, stiffness, pain or other discomfort? Yes No

If yes, please explain_____

_____

Do you have any particular goals in mind for this massage session? Yes No

If yes, please explain_____

Have you had a professional massage before? Yes No

Date of Last Massage_____How often do you get a wellness massage?_____

Do you prefer a deep touch or light touch for you massage?_____

Are you currently under medical supervision? Yes No

If yes, please explain_____

Do you see a chiropractor? Yes No

If yes, how often?_____

Are you currently taking any medication? Yes No

If yes, please list _____

_____

Please explain any condition(s) that you have marked in the sidebar_____

_____

Is there anything else about your health history that you think would be useful for your massage practitioner to know to plan a safe and effective massage session for you?_____

Primary Care Doctor:_____

Chiropractor:_____

Please see other side for page 2

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Please check all of the following conditions that currently apply to you:

- ☐ Low Blood Pressure
- ☐ Migraines
- ☐ Multiple Sclerosis
- ☐ Muscle Spasms
- ☐ Muscle Tension
- ☐ Neuralgia
- ☐ Neuritis
- ☐ Numbness or Tingling _____location
- ☐ Open sore/Wound
- ☐ Osteoporosis
- ☐ Pacemaker or similar device
- ☐ Pain
- ☐ Pinched Nerve
- ☐ Plantar Warts
- ☐ Psoriasis
- ☐ Recent Surgery
- ☐ Phlebitis Thrombosis
- ☐ Pregnancy _____# weeks
- ☐ Sciatica
- ☐ Skin Condition/Rash
- ☐ Sprain/Strain
- ☐ Stiff Neck/Shoulders
- ☐ Stroke/CVA
- ☐ TB
- ☐ Tendonitis
- ☐ Thrombosis-deep vein
- ☐ Thyroid Hi or Low
- ☐ TMJ Disfunction
- ☐ Ulcers
- ☐ Varicose Veins
- ☐ Vision Problems/Loss

Past Conditions

- ☐ Fractured Bones
- ☐ Auto Accidents
  - __0-5 years ago
  - __1-5 years ago
  - __+5 years ago
- ☐ Knocked Unconscious
- ☐ Surgery

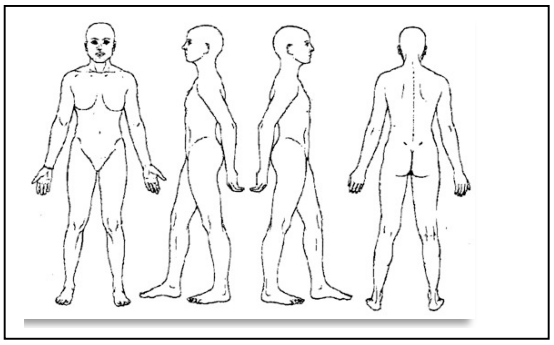
Main Complaint

Location of the pain. Please use the diagrams. Try to be as specific as you can.

_____

_____

_____



Cause of the pain: _____

How long have you had the pain? _____

How frequent is the pain? (all day/night/only when you get up?) _____

How intense is the pain? (scale of 1 –10) _____

How would you describe the pain? (achy, throbbing, burning) _____

What makes the pain increase? _____

What makes the pain decrease? _____

What medications are you presently taking for the condition (muscle relaxants, painkillers?)? _____

Is there a history of this condition? _____

Was the condition related to a work or auto accident? _____

Have you received any other treatment for this condition? If yes, please describe and comment on its success. _____

Scope of Massage Therapy Practice

Massage is defined as the manipulation of the soft tissue of the human body with the hands, arms, elbows, or feet.

I understand that massage 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 that I am aware of. I understand that massage therapists 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. If you are experiencing a condition that contraindicates massage, we may refer you to another healthcare provider.

Ethics & Privacy

Our massage practice is strictly non-sexual. Any behavior that might be interpreted as sexual in nature will result in immediate termination of the session without refund of the session fee. I follow the guidelines of privacy of information according to HIPPA. All information shared during the session is strictly confidential.

Informed Consent

I acknowledge that the information I provided in this form is complete and accurate. I stated all my known medical conditions and medications, and will inform the massage therapist of any changes in my health status. I understand the information provided is strictly confidential. I also understand the scope of massage therapy practice and the policies listed above.

Client Signature_____ Date_____/_____/_____

***Your E-mail address is considered confidential, and will only be used to communicate with you regarding your appointments. If you would like to be added to our e-mail newsletter list to receive news, information, and special offers, please sign here:*

Client Signature_____ Date_____/_____/_____