

Sacred Touch Massage Therapy

Confidential Case History

Name: _____ Phone : (Hm) _____ (Cell) _____

Address: _____ City/State/Zip: _____

Birth Date: ___/___/___ Occupation: _____ Email: _____

Emergency Contact: _____ Phone #: _____

Physician: _____ Current Medications/ Supplements: _____

Chiropractor: _____

How did you hear about our office: _____ * Please allow us to make a copy of medication list if needed

Please circle:

Do you wear contacts? Y / N Do you have a nut allergy? Y / N

Do you exercise regularly? Y / N If yes, what form of exercise? _____

Do you take vitamins? Y / N If yes, what type of vitamins & how often? _____

Do you use a computer? Y / N If yes, hours a day? _____ Days a week? _____

Do you smoke? Y / N Amount: _____

Do you sleep well? Y / N I sleep on my: SIDE ___ STOMACH ___ BACK _____

Professional massage in the past? Y / N Type: _____

Allergies (Oils, Lotion, or ect.) Y / N Explain: _____

Do you have any particular goals for this massage session? _____

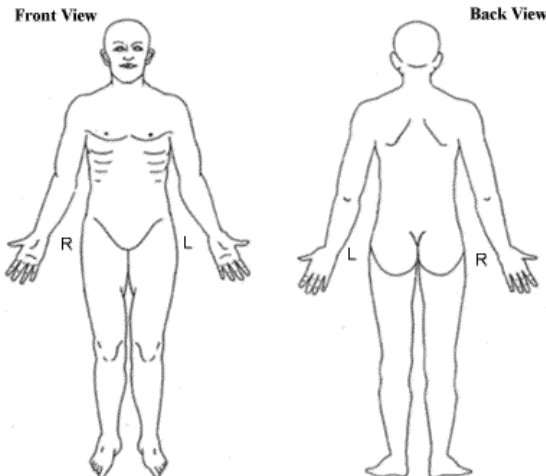
Describe any surgeries, hospitalizations, accidents or injuries you have had:
Less than 5 years ago: _____

More than 5 years ago: _____

What do you consider your energy level to be:

10 9 8 7 6 5 4 3 2 1
(High) (Low)

Circle any specific areas you would like the massage therapists to concentrate on during the session.



Do you have any chronic, ongoing pain that you deal with on a regular basis? Y / N

Please Explain: _____

Describe what activities cause this pain and/or make it worse: _____

Present symptoms, conditions, complaints, and areas of tension or discomfort:

Please check all that apply.

- | | | |
|---|--|--|
| <input type="checkbox"/> Acute Infection | <input type="checkbox"/> Dizziness | <input type="checkbox"/> Muscle Spasms |
| <input type="checkbox"/> Acute Injury | <input type="checkbox"/> Fatigue | <input type="checkbox"/> Nervous Tension |
| <input type="checkbox"/> Arthritis | <input type="checkbox"/> Fibromyalgia | <input type="checkbox"/> Numbness or Tingling |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Hay Fever | <input type="checkbox"/> Phlebitis/ Thrombosis |
| <input type="checkbox"/> Autoimmune Disorder | <input type="checkbox"/> Headaches | <input type="checkbox"/> Athlete's Foot |
| <input type="checkbox"/> Heart Problems | <input type="checkbox"/> Sinus Trouble | <input type="checkbox"/> Cancer |
| <input type="checkbox"/> Herniated Disc | <input type="checkbox"/> Stiff Neck/ Shoulders | <input type="checkbox"/> Chronic Back Pain |
| <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> TMJ Dysfunction | <input type="checkbox"/> Depression |
| <input type="checkbox"/> Insomnia | <input type="checkbox"/> Varicose Veins | <input type="checkbox"/> Diabetes |
| <input type="checkbox"/> Range of Motion Loss | <input type="checkbox"/> Pregnant? Due: Date _____ | |

Anything else not listed about your health history your therapist should be aware of? _____

PLEASE READ CAREFULLY AND SIGN:

An accurate health history ensures that it is safe for you to receive a massage treatment, and helps the therapist determine a proper treatment plan. All information gathered on this form is confidential.

I understand a massage therapist will NEVER touch genitals, breast tissue, or any other areas I instruct them not to touch. I understand that I may be denied services if I behave inappropriately during the session, or have consumed drugs or intoxicating substance prior to my appointment.

I understand the massage therapy given here is for general wellness purposes, including pain, stress reduction, relief from muscular tension and spasm, and the promotion of circulation and flexibility. I understand massage therapists do not diagnose illness, disease or any other physical or mental disorders. Massage therapists do not prescribe medical treatment or pharmaceuticals, nor do they perform any spinal manipulations.

I understand it is my responsibility to keep my therapist informed of any changes in health history and medications prior to further treatment.

You are always in complete control of the treatment you receive from your therapist. We welcome your questions or comments at any time before, during, and after your treatment so that we may adjust the depth/techniques of the massage to achieve optimal results.

I UNDERSTAND THAT A 24 HOUR NOTICE IS REQUIRED FOR A CHANGE OR CANCELLATION ON AN APPOINTMENT OR CHARGES WILL APPLY. MISSED APPOINTMENT CHARGE IS \$25.00.

Client Signature _____ Date _____

Therapist Signature _____ Date _____

Consent to Treatment of Minor: By my signature below, I hereby authorize _____ to administer massage, bodywork, or somatic therapy techniques to my child or dependent as they deem necessary.
Signature of Parent or Guardian: _____ Date: _____