Spirit Massage & Bodywork®
Release your stress, relax your mind!

HEALTH AND WELLNESS INFORMATION

Section 1: Client Information

Last Name: _____ First Name: _____ MI: _____

Address: _____ City: _____ State: _____ Zip: _____

Home #: _____ Work #: _____ Mobile #: _____ Email Address: _____

Sex: ☐ Male ☐ Female DOB: _____ Age: _____ Height/Weight: _____ Occupation: _____

Section 2: Health History

DISCLOSURE: *Voluntary: however, failure to provide the information may result in delays or mistreatment in assessing your overall health and well-being.*
PRINCIPAL PURPOSE(S): *An assessment by your massage therapist of your physical condition is needed to determine necessary modalities to be applied and identify any contraindications for massage.*

Allergies? ☐ Yes ☐ No

Are you pregnant? Due Date: _____ ☐ Yes ☐ No

Have you had any major injuries or surgery in the past 6 months? ☐ Yes ☐ No

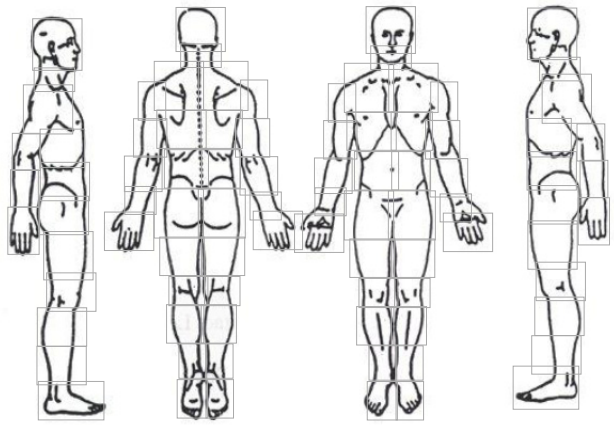
Do you have any area(s) which are sore or sensitive to the touch? ☐ Yes ☐ No

Check conditions or symptoms you currently have or have had in the past:

☐ Anemia	☐ Appendicitis	☐ Arthritis	☐ Blood Clots	☐ Bronchitis	☐ Cancer
☐ Diabetes	☐ Epilepsy	☐ Fractures	☐ Heart Disease	☐ Hepatitis	☐ Herniated Disc
☐ Herpes	☐ High Blood Pressure	☐ Migraine	☐ Muscular Sclerosis	☐ Pacemaker	☐ Pinched Nerve
☐ Pneumonia	☐ Polio	☐ Rheumatic Fever	☐ Sinus Problems	☐ Stroke	☐ Tendonitis
☐ Thyroid Problems	☐ Ulcers	☐ Other			

List any medications: _____

On the figure below, mark the areas where you are experiencing pain, soreness, numbness, tingling, or stiffness.



RATE YOUR PAIN on a 0 to 10 scale

0	1	2	3	4	5	6	7	8	9	10

Have you ever had a PROFESSIONAL MASSAGE? ☐ Yes ☐ No

Massage Pressure Preference

Low			Medium			High		
1	2	3	4	5	6	7	8	9

Your desired intent: ☐ Relax ☐ Improve an existing condition

How often do you want to receive massages?

How did you hear about us? _____

Emergency Contact

Name: _____ Relationship: _____ Phone: _____

Please read and sign: I certify that the above information is correct to the best of my knowledge & hereby request the aforementioned health care providers release to you a report of my diagnosis, treatment, prognosis and recommendations, and other information pertinent to your treatment of me. I understand the services offered are not a substitute for medical care and that any information provided by the massage therapist is not diagnostic or prescriptive in nature. I agree to participate and give consent to receive treatment. I have reported all health conditions that I am aware of and will inform my therapist of any changes in my health. I also know that in some cases the therapists may refer me to another health care practitioner as they may feel is necessary for my best interests. I realize that if I do not give pertinent information regarding my health the therapist may not know the best form of treatment to take and that in some cases my well-being may be at risk.

I acknowledge that my therapist has given me an appointment time which will be exclusively reserved for me. Failure to provide 24 hours' notice of cancelation may result in my account being charged for full session.

Signature: _____ Date: _____