Confidential Health History Questionnaire

Name		Date
Address		
Phone Day: Evening:	Email Date of Birth	
Occupation	Employer	
Emergency Contact	Phone	Relationship
Referred by ☐ Friend, name: _____ ☐ Website: _____ (Google, Facebook, Yelp) ☐ Flyer, location: _____ ☐ Other : _____		
Would you like to be added to the Charm City Massage newsletter: ☐ Yes ☐ No We love sharing our passion for healthy living with our VIP newsletter clients. In each monthly newsletter, we include our current promotion, upcoming events and complimentary seminars, plus relevant tips about movement and self-care.		

Massage History and Treatment Information

Have you ever received a professional massage? If Yes, date of last massage _____ ☐ No

Are you allergic or sensitive to: ☐ Oils ☐ Lotions ☐ Scents ☐ Other? _____

Do you sit for long hours? ☐ Desk, # of hours per day? _____ ☐ Driving, # of hours per day? _____

Do you perform repetitive movements in your work, sports, or hobby? If so, _____

What is your primary reason for receiving today's massage treatment?

☐ Relaxation ☐ Therapeutic / Deep Tissue ☐ Sports event, name and date: _____

☐ Fertility / Prenatal / Postpartum ☐ Other? _____

Would you like work on any of the following areas? ☐ Abdomen / Psoas ☐ Face / Scalp ☐ Sternum / Anterior Ribs

Are there any specific areas you would like avoided? _____

Exercise History and Training Information

Do you currently participate in regular exercise? If Yes, what type?_____ how frequently?_____

Do you belong to a gym? If Yes, which one? _____ How many hours per week do you train?_____

What hobbies or other activities do you enjoy? _____

If completing a Functional Movement Screen or purchasing Performance Training at Charm City Massage, please check your primary reason(s) for receiving this service:

☐ Injury Rehabilitation ☐ Reduce Risk of Injury ☐ Vary My Exercise Programming

☐ Learn Correct Technique ☐ Prepare for Sports / Performance Event _____

Medical History

Primary Care Provider	Phone
Name of Facility or Medical Group	
If necessary, do we have permission to consult with your primary care provider?: ☐ Yes ☐ No	

Are you seeing any other specialists or health care practitioners (ex. neurologist, physical therapist, herbalist)? If yes:

	Name	Reason
1		
2		

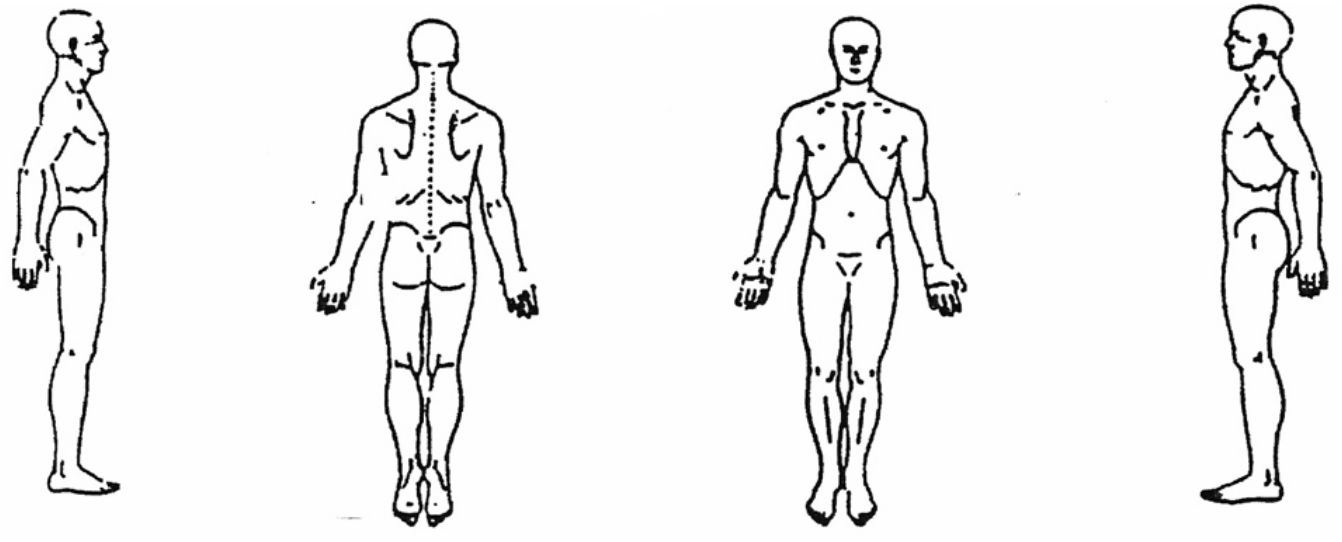
Are you currently experiencing any of the following conditions?

☐ Flu ☐ Inflammation ☐ Fever ☐ Infection ☐ Contagious Disease

Are you currently taking any medications? If yes, provide name and reason for use: _____

_____

Please mark the following diagrams for all areas where you are experiencing tightness, discomfort, or pain:



Please list any surgery you have received during your lifetime:

	Treatment	Year
1		
2		
3		

Please list any major injury or illness that may be relevant to your massage or performance training session:

	Type	Year
1		
2		
3		

Please place a check next to any condition that applies to you:

Musculo-Skeletal

- ☐ Carpal Tunnel Syndrome
- ☐ Strains / Sprains: _____
- ☐ Headaches / Migraines
- ☐ Whiplash / Concussion
- ☐ Joint Stiffness / Swelling
- ☐ Tendinitis: _____
- ☐ Bursitis
- ☐ Spasms / Cramps
- ☐ Broken or Fractured Bones: _____
- ☐ Jaw Pain / TMJ Disorder
- ☐ Osteoarthritis / Gout / Lyme's Disease
- ☐ Osteoporosis / Osteopenia
- ☐ Disc Injury (Herniation or Degenerative Disc Disease)
- ☐ Scoliosis
- ☐ Other Bone or Joint Disease: _____
- ☐ Chronic Fatigue Syndrome / Fibromyalgia
- ☐ Muscular Dystrophy

Circulatory and Immune System

- ☐ Cold Feet or Hands
- ☐ Swollen Ankles
- ☐ Varicose Veins
- ☐ Chest Pain / Angina
- ☐ Cerebral Thrombosis / Stroke
- ☐ Heart Condition: _____
- ☐ High Blood Pressure / ☐ Low Blood Pressure
- ☐ Edema / Lymphedema
- ☐ Blood Clots / Thrombus / Embolism
- ☐ Lupus

Respiratory

- ☐ Shortness of Breath (Emphysema, etc)
- ☐ Seasonal Allergies
- ☐ Sinus Problems
- ☐ Asthma

Skin

- ☐ Open Sores or Wounds
- ☐ Psoriasis
- ☐ Eczema / Dermatitis
- ☐ Fungal Infection (Athlete's Foot, etc)
- ☐ Warts
- ☐ Acne
- ☐ Cosmetic Surgery

Digestive and Urinary

- ☐ Indigestion / Reflux
- ☐ Constipation
- ☐ Bladder / Kidney / Urinary Tract Problems
- ☐ Irritable Bowel Syndrome (IBS)
- ☐ Intestinal Gas / Bloating
- ☐ Diverticulitis
- ☐ Crohn's Disease
- ☐ Ulcerative Colitis

Nervous System

- ☐ Numbness/ Tingling / Neuropathy
- ☐ Sciatica
- ☐ Spinal Cord Injury / Pinched Nerve
- ☐ Paralysis
- ☐ Herpes / Shingles
- ☐ Cerebral Palsy
- ☐ Seizure Disorder (Epilepsy, etc)
- ☐ Multiple Sclerosis
- ☐ Parkinson's Disease

Reproductive System

- ☐ Pregnancy:
  - ☐ Current (due date: _____)
  - ☐ Previous (# of children: _____)
- ☐ Menopause
- ☐ Pelvic Inflammatory Disease
- ☐ Endometriosis
- ☐ Hysterectomy
- ☐ Fertility Concerns
- ☐ Prostate Issue

Other

- ☐ Cancer: Type_____
- ☐ Diabetes
- ☐ HIV/AIDS
- ☐ Sleep Disorder
- ☐ Coffee / Caffeine Habit
- ☐ Drug Habit
- ☐ Anxiety / Panic Attacks
- ☐ Depression
- ☐ Other: _____

Consent and Contract for Care

Complete your name, signature, and date for the service(s) you are receiving at Charm City Massage.

Massage Therapy

I choose to receive massage therapy and I give my consent to receive treatment. I have completed the health intake correctly to the best of my knowledge and will inform the massage therapist of any change(s) in my physical health.

I understand that a massage therapist cannot diagnose illness, disease, or any other medical, mental, or emotional disorder. Nor do they prescribe medical treatment, pharmaceuticals, or perform spinal thrust manipulations. I realize that the treatment is being given for the well being of my body, mind and spirit. This includes stress reduction, relief from muscular tension, spasm or pain, and for increasing circulation or energy flow. I acknowledge that massage is not a substitute for medical examinations or diagnosis. I am responsible for consulting a qualified physician for any physical ailments that I have.

I understand that massage therapy is a therapeutic health aide and is nonsexual. The massage may not include any sexual language, references or actions. If any occur, the session will end immediately.

Each massage is tailored to a client's individual needs. I promise to make my therapist aware of any discomforts including room temperature, music, pressure, etc during a session. I promise to communicate with the therapist, as necessary, during the massage session, but I understand that this is my time to heal – and should be used as efficiently as possible.

My signature indicates that I am in good health and free from communicable diseases; that I promise to report before subsequent sessions any injuries and/or communicable diseases should they occur in the future; that I have read and understand the "Health History Questionnaire" document.

Note: Clients under the age of 17 must provide informed written consent and be accompanied by a parent or legal guardian during the entire session.

Name: _____ Date: _____

Signature: _____

Performance Training

I choose to participate in performance training at Charm City Massage and I understand that it entails physical activity. I do affirm that I am in good physical health and can handle the activities for which I have enrolled.

I acknowledge that personal training is not a substitute for medical examinations or diagnosis. I am responsible for consulting a qualified physician for any physical ailments that I have.

I promise to make my trainer aware immediately of any discomfort during a session. I promise to communicate with the trainer, as necessary, if any movement or exercise does not feel comfortable or stable.

My signature indicates that I am in good health and free from communicable diseases; that I promise to report before subsequent sessions any injuries and/or communicable diseases should they occur in the future; that I have read and understand the "Health History Questionnaire" document.

Name: _____ Date: _____

Signature: _____