Restoration Massage & Bodywork

HEALTH HISTORY INTAKE QUESTIONNAIRE

Name:_____ Date of initial visit:_____
Address:_____ Home Phone:_____
City:_____ State:_____ Zip:_____ Cell Phone:_____
Date of birth:_____ Sex: M___ F___ Occupation:_____
Emergency contact:_____ Phone:_____
Name of Physician:_____ Phone:_____
Other health care provider:_____ Phone:_____
Where did you hear about us: **Mobile____Google____Yahoo____Yellowpages____Referral_____**
Email address for specials: _____

1. Have you had massage therapy before? Yes No How long since your last session? _____

2. For women: Are you pregnant? Yes No If yes, how many months? _____

3. Do you have any difficulty lying on your front, back, or side? Yes No
   If yes, please explain._____

4. Do you have allergic reaction to lotions, ointments, liniments, or other substances put on your skin?
   Yes No If yes, please explain._____

5. Do you wear contact lens( ) dentures( ) hearing aid ( )?

6. Do you sit for long hours at a workstation, computer, or driving? Yes No
   If yes, please explain_____

7. Do you perform any repetitive movement in your work, sports, or hobby? Yes No
   If yes, please explain_____

8. Do you experience stress in your work, family, or other aspect of your life? Yes No
   How would you describe your stress level? Low Medium High Very high
   If high, how do you think stress has effected your health? Muscle tension( ) Anxiety( ) Insomnia( )
   Irritability( ) Other_____

9. Is there a particular area of the body where you are experiencing tension, stiffness, or other discomfort?
   Yes No If yes, please explain_____

10. Are you under medical supervision? Yes No
    If yes, please explain_____

11. Are you currently taking any medication? Yes No
    If yes, please explain_____

12. Please check any condition listed below that applies to you:

_____ Skin condition (eg, acne, rash, skin cancer, allergy, easy bruising, contagious condition)
_____ Allergies
_____ Recent accident, injury, or surgery (eg, whiplash, sprain, broken bone, deep bruise)
_____ Muscular problems (eg, tension, cramping, chronic soreness)
_____ Joint problems (eg, osteoarthritis, rheumatoid arthritis, gout, hypermobile joints, dislocation)
_____ Lymphatic condition (eg, swollen glands, nodes removed, lymphoma, lymphedema)
_____ Circulatory or blood conditions (eg, atherosclerosis, varicose veins, phlebitis, arrhythmias, or low blood pressure, heart disease, recent heart attack or stroke, anemia)
_____ Neurologic condition (eg, numbness or tingling in any area of the body, sciatica, damage from stroke, epilepsy, multiple sclerosis, cerebral palsy)
_____ Digestive conditions (eg, ulcers, spastic colon)
_____ Immune system conditions (eg, chronic fatigue, HIV/AIDS, Lupis)
_____ Skeletal conditions (eg, osteoporosis, bone cancer, spinal injury)
_____ Headaches (eg, tension, PMS, migraines)
_____ Cancer
_____ Emotional difficulties (eg, depression, anxiety, panic attacks, eating disorder, psychotic episodes). Are you currently seeing a psychotherapist for this condition? Yes No
_____ Previous surgery, disease, or other medical condition that may be affecting you now (eg, polio, previous heart attack or stroke, previously broken bones)

Comments:

_____

_____

13. 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?

_____

_____

14. Has your physician or other health care provider recommended massage for any of the conditions listed #12? Yes No If yes, please explain_____

15. Do you have any particular goals in mind for this massage session related to any of the conditions mentioned above? Yes No If yes, please explain_____

I understand the massage / bodywork I receive is provided for the basic purpose of relaxation and relief of muscular tension. If I experience any pain or discomfort during any session, I will immediately inform the therapist. I further understand massage or bodywork should not be construed as a substitute for medical examination, diagnosis, or treatment. Because massage / bodywork should not be performed under certain medical conditions, I affirm that I have stated all my known medical conditions and answered all questions honestly. Also, if specific medical conditions were noted, I have cleared receiving massage with my primary care provider.

I agree to keep the practitioner updated as to any changes in my medical profile and understand there shall be no liability on the practitioner's part should I fail to do so. I also understand that any illicit or sexually suggestive remarks or advances or any other inappropriate action made by me (the client/patient) will result in immediate termination of the session. I also understand all sessions must be paid in full at the end of each session. I understand that the massage therapist has the right to refuse service at any time or for any reason.

Print Name: _____

Signature: _____ Date: _____

Cancellation Notice Policy
Restoration Massage & Bodywork Therapies

Appointments will be given a reminder phone call the day before any appointment unless verbal acknowledgement is done on the previous visit (multiple session clients). Client must provide a phone # where they can be reached and/or a message may be left.

24 hour advanced notice must be received for massage therapy or a charge of **50% of total fees will be charged**. Fees must be paid before another appointment may be made.
If this is a medical case, this is not paid by insurance companies and is the responsibility of the client.

I_____(print name) understand the cancellation policy and accept responsibility for any fees for any session not cancelled within the acceptable time frame and agree to pay all fees associated with the missed appointment.

Signature:_____ Date:_____

Practitioner/Clinic Name: Restoration Massage & Bodywork

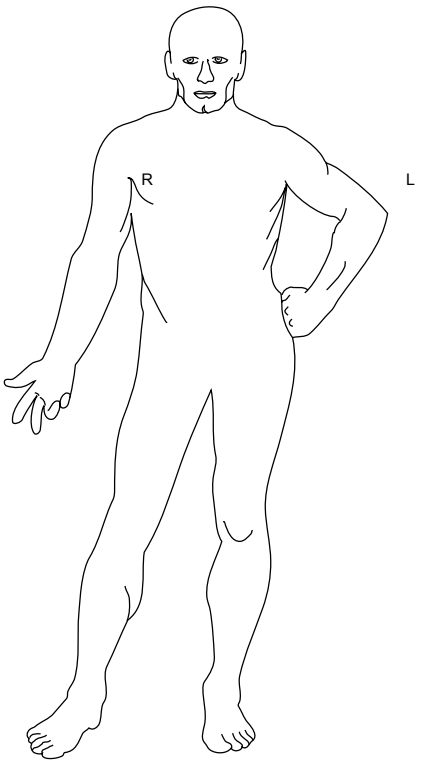
Health Status Update

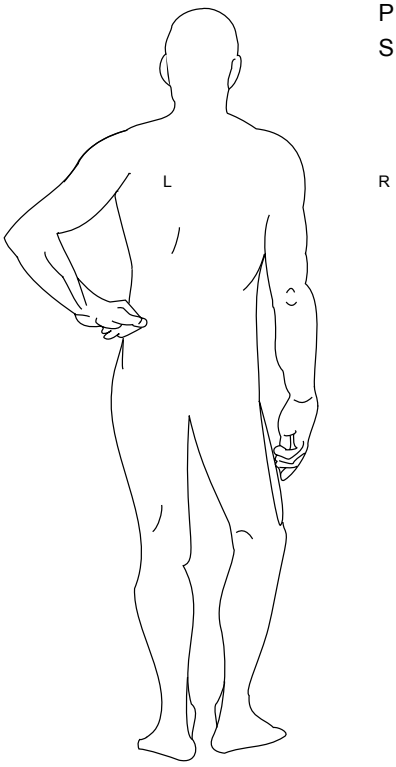
Contact Information: 615-494-3277

Client Information

Client Name: _____ Date: _____ Date of Birth: _____

Depict how you are feeling today by drawing a circle on the figures representing the size and shape of the following symptoms. Place the letter representing the symptoms in or near the circle:





P = Pain, ache, or tenderness
S = Stiffness in the joint or muscle

Rate how you are feeling today by drawing a circle around the number that best represents how you are doing today:

No pain	0	1	2	3	4	5	6	7	8	9	10	Worst pain imaginable
Able to do everything	0	1	2	3	4	5	6	7	8	9	10	Not able to do anything

Comments

Is there anything else I should know about how you are feeling today or about your progress or care to date?

_____

_____

_____

Signature: _____ Date: _____