

Client Health Screen

Name _____
Address _____
Phone Work _____ Cell _____ Home _____
Email _____
Birthday _____
Referred by _____

Your answers to the questions below will aid me in determining an appropriate treatment plan.

When was your last massage? _____

Are you currently being treated for any of the following disorders, conditions, and/or symptoms?

- | | | |
|---|--|-------|
| <input type="checkbox"/> high blood pressure | <input type="checkbox"/> epilepsy | _____ |
| <input type="checkbox"/> low blood pressure | <input type="checkbox"/> HIV/AIDS | _____ |
| <input type="checkbox"/> heart disease | <input type="checkbox"/> hepatitis | _____ |
| <input type="checkbox"/> aneurysm | <input type="checkbox"/> pregnancy | _____ |
| <input type="checkbox"/> herniated disk | <input type="checkbox"/> varicose veins | _____ |
| <input type="checkbox"/> osteoarthritis | <input type="checkbox"/> mental illness | _____ |
| <input type="checkbox"/> rheumatoid arthritis | <input type="checkbox"/> frequent headaches | _____ |
| <input type="checkbox"/> osteoporosis | <input type="checkbox"/> skin sensitivity | _____ |
| <input type="checkbox"/> asthma | <input type="checkbox"/> inner ear problems | _____ |
| <input type="checkbox"/> cancer | <input type="checkbox"/> easy bruising | _____ |
| <input type="checkbox"/> diabetes | <input type="checkbox"/> other (next column) | _____ |

Please list any prescription medications you are taking. _____

Have you had surgery within the past year? If yes, what kind? _____

Have you ever suffered a serious injury? If yes, what was the nature of the injury? _____

Do you wear contact lenses? _____ a hearing aid? _____ dentures? _____

Are there parts of your body you particularly want me to massage? _____

Are there parts of your body you particularly want me to avoid? _____

Is there anything else you believe I should know before you receive a massage from me?

I have answered the questions above as fully as possible, and I have reviewed the statement above. I understand that massage does not constitute medical treatment. It is a form of health and wellness maintenance that uses a combination of massage techniques. I take responsibility for alerting the massage therapist to any conditions that would affect this work.

Signature of Client: _____ Date: _____

I have reviewed this completed form with the client.

Signature of LMT: _____ License #: _____ Date: _____

Practice Policies

Please refrain from wearing scented products on the day of your appointment.

Please pay for appointments you cancel with less than 24 hours' notice.

The focus of my practice is to help clients reduce and manage physical, mental, emotional, and/or spiritual stress. The physical work of massage can help reduce stress at any of these levels, as can the subtle work of energy balancing. I rarely distinguish between them as I'm working. You may or may not notice the difference; please ask questions whenever they arise for you.

I will recommend a treatment program based on how much stress you are experiencing and how readily you respond to the first treatment. As a general rule, I will recommend no less than one massage a month, but initially, I may suggest that you come more frequently until we have reduced your stress to a manageable level.

I may make suggestions for self-care.

I may recommend that you see practitioners of other modalities to achieve maximal results.

I will not share any of your personal information with anyone without your explicit, written permission.

I can provide a coded receipt.

I have read and I agree to these practice policies.

Signature: _____ Date: _____

Printed Name: _____