



# Cloud Hands Healing Arts

## Health History Form

Name \_\_\_\_\_ Phone ( ) \_\_\_\_\_

Address \_\_\_\_\_ City \_\_\_\_\_

State \_\_\_\_\_ Zip \_\_\_\_\_

**E-mail:** \_\_\_\_\_ (to receive special seasonal Massage rates and health information)

Referred by: \_\_\_\_\_ Phone ( ) \_\_\_\_\_

In case of emergency: \_\_\_\_\_

Emergency Phone ( ) \_\_\_\_\_

Occupation \_\_\_\_\_ Age \_\_\_\_\_ Male \_ Female \_

Physician \_\_\_\_\_

**Please take a moment to carefully read the following information and sign where indicated. If you have a specific medical condition or specific symptoms, massage/bodywork may be contraindicated. A referral from your primary care provider may be required prior to service being provided. All personal or medical information is completely confidential.**

Have you ever experienced a professional massage or bodywork session?

Yes  No How recently? \_\_\_\_\_

What are your massage or bodywork goals? \_\_\_\_\_

What kind of pressure do you prefer?  light  medium  firm

***If you answer "yes" to any of the following questions, please explain as clearly as possible.***

Yes  No Do you frequently suffer from stress?

Yes  No **Do you have diabetes?**

Yes  No Do you experience frequent headaches?

Yes  No **Are you pregnant?**

Yes  No Do you have any allergies?

- Yes  No Are you wearing contact lenses?
- Yes  No Are you wearing dentures?
- Yes  No Do you suffer from epilepsy or seizures?
- Yes  No Do you have any contagious diseases?
- Yes  No Do you suffer from arthritis or fibromyalgia?
- Yes  No Do you suffer from joint swelling?
- Yes  No **Do you have varicose veins?**
- Yes  No **Do you have cardiac or circulatory problems?**
- Yes  No **Do you have high blood pressure?**
- Yes  No **Are you taking high blood pressure medication?**
- Yes  No **Do you bruise easily?**
- Yes  No Any broken bones in the past two years?
- Yes  No **Any injuries in the past five years?**
- Yes  No Do you have tension or soreness in a specific area?

Please specify \_\_\_\_\_

- Yes  No Do you have osteoporosis?
- Yes  No Do you suffer from back pain?
- Yes  No Do you have numbness or stabbing pains?
- Yes  No **Are you sensitive to touch or pressure in any area?**
- Yes  No **Have you ever had surgery? When and for what?**

\_\_\_\_\_  
 Yes  No Other medical conditions?

\_\_\_\_\_  
 Yes  No Are you taking any medications I should know about, including over the counter pain relievers such as aspirin or Tylenol?

\_\_\_\_\_

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### **Comfort Level:**

Are there any places of your body that are uncomfortable to touch, such as ticklish feet, scars, etc.? \_\_\_\_\_

Questions sometimes arise about disrobing, and how much. This is something we can discuss before your session, but basically, it depends on your comfort level. The more you disrobe, the more areas we will be able to work on.

Either way, you will be covered completely during your massage, except for the one area that is being addressed. This is an extremely professional experience, and your comfort level is first priority.

I understand that 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 this session, I will immediately inform the practitioner so that the pressure and/or strokes may be adjusted to my level of comfort. I further understand that massage or bodywork should not be construed as a substitute for medical examination, diagnosis, or treatment and that I should see a physician, or other qualified medical specialist for any mental or physical ailment of which I am aware. I understand that massage/bodywork practitioners are not qualified to perform spinal or skeletal adjustments, diagnose, prescribe, or treat any physical or mental illness, and that nothing said in the course of the session given should be construed as such. 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. I agree to keep the practitioner updated as to any changes in my medical profile and understand that there shall be no liability on the practitioner's part should I fail to do so.

Client Signature \_\_\_\_\_ Date \_\_\_\_\_

Parent Signature \_\_\_\_\_ Date \_\_\_\_\_