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?

_____

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 _____