Body Poets Massage Therapy Health History Form

Thank you for filling out this confidential form. It allows us to design a safe and effective treatment for you, working toward your health goals. Our privacy policy is posted in the clinic and on our website: we will only release this information with your consent except as required by law. If any of your health or contact information changes in the future, please let us know so that we can continue to work together safely and effectively.

Name _____ Date _____

Phone (day) _____ (eve) _____ (cell) _____

Address _____ City_____ Postal Code _____

E-mail _____ Birth date _____

Emergency contact name _____ Phone _____

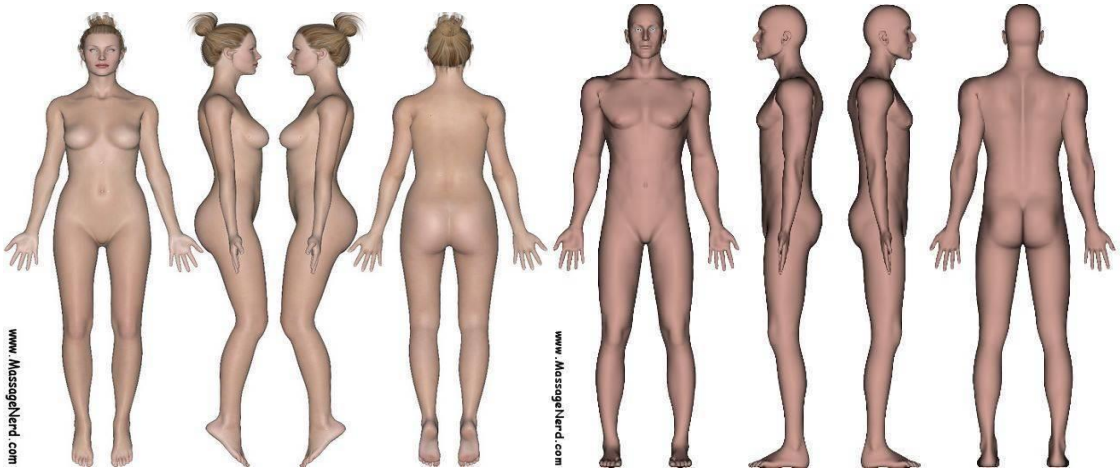
How did you hear about us? _____ Is this your first massage? ❑ Yes ❑ No

Did a health care provider refer you? ❑ Yes ❑ No If yes, why? _____

Stay up-to-date about promos, news and advice with our monthly email-newsletter. ❑ Yes ❑ No

Why would you like massage therapy today? _____

Please circle any areas of your body where you would like to feel more comfortable today



Please list the treatments or medications you have used or taken in the last 24 hours

Any other medications you are currently taking and the conditions they treat

_____

History of accidents and injuries (e.g. serious sprain or fall, motor vehicle accident, broken bones)

_____

History of surgeries _____

Name & full contact of MD/care provider _____

Other health care you are currently using _____

Please complete page 2

Please check all of the following conditions that affect you:

Blood and Cardiovascular
- ❑ Chronic congestive heart failure
- ❑ Heart attack
- ❑ Heart disease
- ❑ Blood pressure: high or low (circle one)
- ❑ Pacemaker or similar device
- ❑ Phlebitis or varicose veins
- ❑ Stroke/CVA
- ❑ Hemophilia

Respiratory
- ❑ Asthma
- ❑ Bronchitis
- ❑ Chronic cough
- ❑ Emphysema
- ❑ Shortness of breath

Infections
- ❑ Hepatitis
- ❑ Herpes
- ❑ HIV
- ❑ Lyme Disease
- ❑ TB

Head and Neck
- ❑ Hearing problems
- ❑ History of headaches
- ❑ History of migraine
- ❑ Vision problems
- ❑ Tinnitus

Musculoskeletal
- ❑ Osteoarthritis
- ❑ Osteoporosis
- ❑ Rheumatoid arthritis
- ❑ Scoliosis

Nervous System
- ❑ Epilepsy
- ❑ Multiple sclerosis
- ❑ Mental health concerns:_____

Other
- ❑ Anemia (Low iron)
- ❑ Cancer
- ❑ Diabetes
- ❑ Digestive conditions
- ❑ Endometriosis
- ❑ Fibromyalgia
- ❑ Lupus
- ❑ Skin conditions: _____
- ❑ Thyroid imbalance: high or low (circle one)
- ❑ Tingling or loss of sensation in: _____
- ❑ Allergies or hypersensitivity to: _____
- ❑ If pregnant, when due: _____

Is there a family history of any of the above conditions? ❑ Yes ❑ No

Briefly, which ones? _____

Do you have any internal pins, wires, artificial joints or special equipment? ❑ Yes ❑ No

If yes, please explain: _____

Is there anything else we should know about your health before we begin our treatment? ❑ Yes ❑ No

If yes, please explain: _____

CONSENT TO RELEASE OF INFORMATION: "If an insurance company asks Body Poets to confirm whether I have received treatment at the clinic on a specific date, I agree that the clinic can provide that information."

CANCELLATION POLICY: Please contact us at least 24 hours before your appointment start time to change or cancel your appointment, or you will be charged the full fee for the appointment. You may always send a friend in your place!

Client Signature _____ Initial Date_____

Update 1 _____ Update 2 _____ Update 3 _____ Update 4_____