Client Health History

Patient Name: _____

Parent Name: _____ **Phone:** _____

Full Street Address: _____

Grade in School: _____ **Patient Date of Birth:** _____

Are you currently seeing a doctor? Y N

What is the diagnosis?

_____

Was massage prescribed for you? Y N

Do you currently take any medications? Y N

_____

Birth Experience: _____

_____

_____

Do you have any allergies? Y N

_____

Do you have any skin conditions? Y N

_____

Please list any previous illnesses, injuries or surgeries:

Muscular (strains/stiffness/soreness) _____

Skeletal (breaks/sprains) _____

Head injury/TMJ/orthodonture _____

Circulatory _____

Respiratory (sinus/tonsils/asthma)_____

Digestive (stomach/intestines) _____

Nervous (cognitive/behavioral/sleep) _____

Reproductive/Urogenital _____

Infectious or inflammatory disease_____

Cancer _____

Explain your treatment and any lasting effects:

_____

_____

What do you do when you play (sports, hobbies, etc)?

_____

_____

_____

How would you describe your diet?

_____

_____

_____

Client Health History

Have you received massage or bodywork before? Y N

What kinds and how often: _____

What did you like? _____ What didn't you like? _____

What would you like to gain from receiving massage, today and in the future?

_____

_____

How have you been feeling?

_____

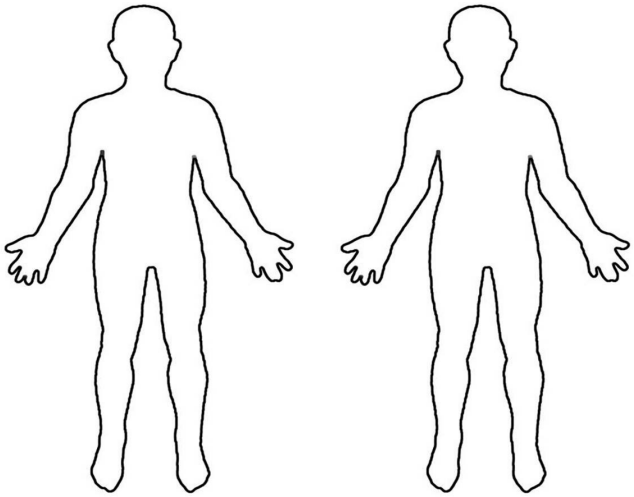
_____

Please mark areas of:

stress
pain or tenderness
numbness or weakness
inflammation

Where you want special attention

Where you don't want to be touched
(breasts and genitals are never touched)



I realize that the treatment is being given for the well-being of my body and mind. This includes stress reduction, relief from muscular tension, spasm or pain, treatment of injury, or for increasing circulation. I agree to inform my practitioner any time I feel that my well-being is being compromised.

I understand that massage practitioners do not diagnose illness or any mental disorder; nor do they prescribe medical treatment. I acknowledge that massage is not a substitute for medical examination or diagnosis, and that it is recommended that I see a primary health care provider for that service.

I have stated all medical conditions that I am aware of and will update the massage practitioner of any changes in my health status. I understand that these health records are confidential, and authorize Lauren Christman, as my massage practitioner, to contact my health care providers if necessary.

If necessary, I authorize Lauren Christman, as my massage practitioner, to release any medical records to insurance or legal representatives for billing purposes. I understand and agree to the fees and billing policies of my practitioner as described on her website: www.craftedtouch.com.

Patient Signature _____ **Date** _____

Parent/Custodian Signature _____ **Date** _____