

# Client Health History

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Patient Name: \_\_\_\_\_

Parent Name: \_\_\_\_\_ Phone: \_\_\_\_\_

Full Street Address: \_\_\_\_\_

Occupation: \_\_\_\_\_ Patient Date of Birth: \_\_\_\_\_

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Are you currently seeing a doctor? Y N

What is the diagnosis?

\_\_\_\_\_

Was massage prescribed for you? Y N

Are you pregnant or trying to be? Y N

Previous pregnancies: \_\_\_\_\_

\_\_\_\_\_

Do you have any allergies? Y N

\_\_\_\_\_

Do you currently take any medications? Y N

\_\_\_\_\_

Do you have any skin conditions? Y N

\_\_\_\_\_

**Please list any previous illnesses, injuries or surgeries:**

Muscular (strains/stiffness) \_\_\_\_\_

Skeletal (breaks/sprains) \_\_\_\_\_

Head injury/TMJ/orthodonture \_\_\_\_\_

Circulatory \_\_\_\_\_

Respiratory \_\_\_\_\_

Digestive \_\_\_\_\_

Nervous \_\_\_\_\_

Reproductive/Urogenital \_\_\_\_\_

Infectious disease \_\_\_\_\_

Cancer \_\_\_\_\_

Explain your treatment and any lasting effects:

\_\_\_\_\_

\_\_\_\_\_

**How do you exercise and in what ways?**

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

**How would you describe your diet?**

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

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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?

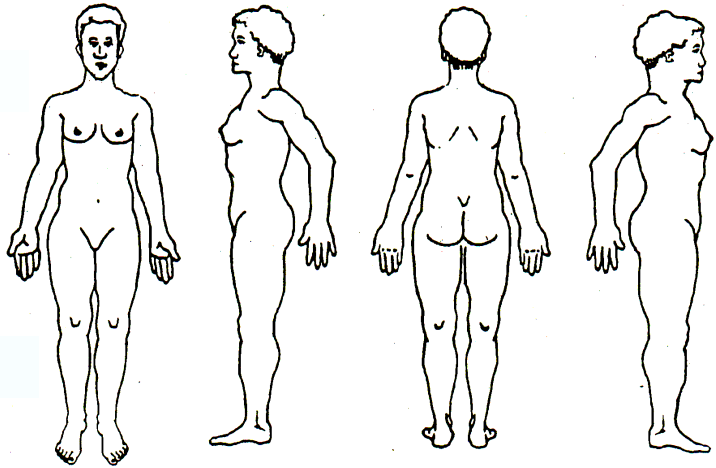
\_\_\_\_\_  
\_\_\_\_\_

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)



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*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 Richard Polishuk, as my massage practitioner, to contact my health care providers if necessary.*

*If necessary, I authorize Richard Polishuk, 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](http://www.craftedtouch.com).*

**Patient Signature** \_\_\_\_\_ **Date** \_\_\_\_\_

**Parent/Custodian Signature** \_\_\_\_\_ **Date** \_\_\_\_\_