

# Client Health History

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

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

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

Grade in School: \_\_\_\_\_ 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

Birth Experience: \_\_\_\_\_

\_\_\_\_\_

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 (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 \_\_\_\_\_

COVID/MIS-C \_\_\_\_\_

Explain your treatment and any lasting effects:

\_\_\_\_\_

\_\_\_\_\_

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

**How would you describe your diet?**

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

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**Have you received 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 this session, today and in the future?**

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

**How have you been feeling?**

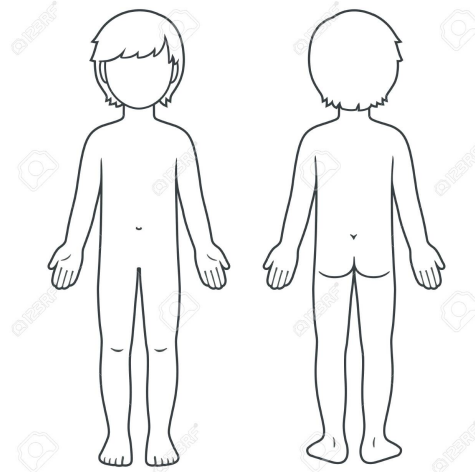
\_\_\_\_\_  
\_\_\_\_\_

**Please mark areas of:**

- stress
- pain or tenderness
- numbness or weakness

Where you want special attention

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



*front*

*back*

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*I realize that treatment is being given for the well-being of my body and mind. I agree to tell Richard if I feel uncomfortable at any point. I understand that massage practitioners do not diagnose illness/disorders; nor do they prescribe medical treatment. I acknowledge that massage is not a substitute for medical examination or diagnosis, and it is recommended that I see a primary health care provider for that. I have stated all medical conditions that I am aware of and will update Richard of changes in my health. I understand these health records are confidential, and authorize Richard Polishuk, as my massage practitioner, to contact my health care providers if necessary.*

*I understand and agree to the billing policies as described on his website: [www.craftedtouch.com](http://www.craftedtouch.com). Initial sessions last 1 hour; on-going care often requires shorter sessions. Fees are prorated by the quarter hour if sessions end early.*

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

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