

Please Print

## Client Personal Health Information/The Comfort Zone

Date \_\_\_\_\_  
Referred By \_\_\_\_\_  
Name \_\_\_\_\_ Address \_\_\_\_\_  
City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_  
Home Phone \_\_\_\_\_ Business \_\_\_\_\_ Cell \_\_\_\_\_  
Occupation \_\_\_\_\_ Birthdate \_\_\_\_\_  
In case of Emergency \_\_\_\_\_ Phone \_\_\_\_\_

### Health Information:

Are you currently under a Doctor's Care? \_\_\_\_\_ If Yes, Please explain \_\_\_\_\_  
Pregnant? \_\_\_\_\_ weeks (\_\_\_\_\_)

Personal Family Physician \_\_\_\_\_ Phone \_\_\_\_\_

Please List any medications you are currently taking, including aspirin, ibuprofen, birth control pills, etc. \_\_\_\_\_

List Surgeries/Accidents (including year and treatment received) in the last 5 years. \_\_\_\_\_

Overall Physical Condition \_\_\_\_\_ Any serious diseases or disabilities \_\_\_\_\_

Do you exercise \_\_\_\_\_ How Often? \_\_\_\_\_ What Type? \_\_\_\_\_

Daily Intake of water \_\_\_\_\_ Caffeine \_\_\_\_\_

Please look over the list of health disorders and check all that apply. There is a space at the end if you need to list any explanations.

- |   |   |   |
|---|---|---|
| <input type="checkbox"/> Bone or Joint Disease                | <input type="checkbox"/> Allergies                | <input type="checkbox"/> Tendonitis     |
| <input type="checkbox"/> Rashes                               | <input type="checkbox"/> Bursitis                 | <input type="checkbox"/> Athletes Foot  |
| <input type="checkbox"/> Broken/Fracture Bones                | <input type="checkbox"/> Warts                    | <input type="checkbox"/> Arthritis      |
| <input type="checkbox"/> Constipation                         | <input type="checkbox"/> Neck/Shoulder/Arm Pain   | <input type="checkbox"/> Diverticulitis |
| <input type="checkbox"/> Low Back/Hip/Leg Pain                | <input type="checkbox"/> Irritable Bowel Syndrome | <input type="checkbox"/> Fatigue        |
| <input type="checkbox"/> Headaches/head injuries              | <input type="checkbox"/> Herpes/Shingles          | <input type="checkbox"/> Sleep Disorder |
| <input type="checkbox"/> Spasm/Cramps                         | <input type="checkbox"/> TMJ/Jaw Pain             | <input type="checkbox"/> Anxiety        |
| <input type="checkbox"/> Sprains/Strains                      | <input type="checkbox"/> Depression               | <input type="checkbox"/> Endometriosis  |
| <input type="checkbox"/> Varicose Veins                       | <input type="checkbox"/> Cancer/Tumors            | <input type="checkbox"/> PMS/PMDD       |
| <input type="checkbox"/> Diabetes/Type? _____                 | <input type="checkbox"/> Infectious Diseases      | <input type="checkbox"/> Lymphedema     |
| <input type="checkbox"/> High/Low Blood Pressure              | <input type="checkbox"/> Eating Disorder          | <input type="checkbox"/> Bruise Easily  |
| <input type="checkbox"/> Drug/Alcohol Disorder                | <input type="checkbox"/> Sinus Problems           | <input type="checkbox"/> Blood Clots    |
| <input type="checkbox"/> Breathing Difficulties               | <input type="checkbox"/> Heart Conditions/Disease | <input type="checkbox"/> Asthma         |
| <input type="checkbox"/> Nicotine/Caffeine Addiction          | <input type="checkbox"/> Chronic Pain             |   |
| <input type="checkbox"/> Fibromyalgia/Myofacial Pain Syndrome |   |   |

If you Checked any disorders or diseases above please use the next few lines to explain. (example....Dates, areas of disorder/disease, type, symptoms of concern. Please be specific.) \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Have you ever received a Professional Massage: \_\_\_ Yes \_\_\_ No

If Yes, Frequency \_\_\_\_\_ Date of last message \_\_\_\_\_

What results do wish to receive from your massage session? (relaxation, pain relief, stress relief) \_\_\_\_\_

Please read the statements below and then sign and date:

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 stroke may be adjusted to my level of comfort. I further understand that massage/bodywork should not be construed as a substitute for medical examination, diagnosis, or treatment and that I should see a physician, chiropractor or other qualified medical specialist for any mental or physical ailment that I am aware of. 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 if I fail to do so. I also understand that any illicit or sexually suggestive remarks or advances made by me will result in immediate termination of the session and I will be liable for payment of scheduled appointment.

\*Appointments not cancelled 24 hours in advance will be charged a \$25.00 service fee. (If you have a gift certificate it will be deducted from your G.C. on your next visit)

I AM OF LAWFUL AGE (18) AND HAVE READ AND FULLY UNDERSTAND the contents of this document and represent myself as physically capable of using the services offered by this facility.

Signature \_\_\_\_\_ Date \_\_\_\_\_  
Practitioners Signature \_\_\_\_\_ Date \_\_\_\_\_

Consent to treatment of MINOR: I hereby authorize \_\_\_\_\_, to administer massage/bodywork techniques to my child or dependent as they deem necessary.  
Signature of Parent or Guardian \_\_\_\_\_

\*\* If you are interested in receiving e-coupons or specials in the future please list an internet e-mail below or a business or home fax number.

\_\_\_\_\_ (e-mail address)

\_\_\_\_\_ (business or home fax no.)