

On Site/ Personal Health Information/The Comfort Zone

Date _____

Name _____ Phone: _____

Address: _____

Health Information:

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

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 _____

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

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. 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 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 _____

