

Restoration Massage & Bodywork
HEALTH HISTORY INTAKE QUESTIONNAIRE

Name: _____ Date of initial visit: _____
Address: _____ Home Phone: _____
City: _____ State: _____ Zip: _____ Cell Phone: _____
Date of birth: _____ Sex: M ___ F ___ Occupation: _____
Emergency contact: _____ Phone: _____
Name of Physician: _____ Phone: _____
Other health care provider: _____ Phone: _____
Where did you hear about us: **Mobile** ___ **Google** ___ **Yahoo** ___ **Yellowpages** ___ **Referral** ___
Email address for specials: _____

1. Have you had massage therapy before? Yes No How long since your last session? _____
2. For women: Are you pregnant? Yes No If yes, how many months? _____
3. Do you have any difficulty lying on your front, back, or side? Yes No
If yes, please explain. _____
4. Do you have allergic reaction to lotions, ointments, liniments, or other substances put on your skin?
Yes No If yes, please explain. _____
5. Do you wear contact lens() dentures() hearing aid ()?
6. Do you sit for long hours at a workstation, computer, or driving? Yes No
If yes, please explain _____
7. Do you perform any repetitive movement in your work, sports, or hobby? Yes No
If yes, please explain _____
8. Do you experience stress in your work, family, or other aspect of your life? Yes No
How would you describe your stress level? Low Medium High Very high
If high, how do you think stress has effected your health? Muscle tension() Anxiety() Insomnia()
Irritability() Other _____
9. Is there a particular area of the body where you are experiencing tension, stiffness, or other discomfort?
Yes No If yes, please explain _____
10. Are you under medical supervision? Yes No
If yes, please explain _____
11. Are you currently taking any medication? Yes No
If yes, please explain _____

12. Please check any condition listed below that applies to you:

- Skin condition (eg, acne, rash, skin cancer, allergy, easy bruising, contagious condition)
- Allergies
- Recent accident, injury, or surgery (eg, whiplash, sprain, broken bone, deep bruise)
- Muscular problems (eg, tension, cramping, chronic soreness)
- Joint problems (eg, osteoarthritis, rheumatoid arthritis, gout, hypermobile joints, dislocation)
- Lymphatic condition (eg, swollen glands, nodes removed, lymphoma, lymphedema)
- Circulatory or blood conditions (eg, atherosclerosis, varicose veins, phlebitis, arrhythmias, or low blood pressure, heart disease, recent heart attack or stroke, anemia)
- Neurologic condition (eg, numbness or tingling in any area of the body, sciatica, damage from stroke, epilepsy, multiple sclerosis, cerebral palsy)
- Digestive conditions (eg, ulcers, spastic colon)
- Immune system conditions (eg, chronic fatigue, HIV/AIDS, Lupis)
- Skeletal conditions (eg, osteoporosis, bone cancer, spinal injury)
- Headaches (eg, tension, PMS, migraines)
- Cancer
- Emotional difficulties (eg, depression, anxiety, panic attacks, eating disorder, psychotic episodes). Are you currently seeing a psychotherapist for this condition? Yes No
- Previous surgery, disease, or other medical condition that may be affecting you now (eg, polio, previous heart attack or stroke, previously broken bones)

Comments:

13. Is there anything else about your health history that you think would be useful for your massage practitioner to know to plan a safe and effective massage session for you?

14. Has your physician or other health care provider recommended massage for any of the conditions listed #12? Yes No If yes, please explain_____

15. Do you have any particular goals in mind for this massage session related to any of the conditions mentioned above? Yes No If yes, please explain_____

I understand 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 any session, I will immediately inform the therapist. I further understand massage or bodywork should not be construed as a substitute for medical examination, diagnosis, or treatment. 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. Also, if specific medical conditions were noted, I have cleared receiving massage with my primary care provider.

I agree to keep the practitioner updated as to any changes in my medical profile and understand there shall be no liability on the practitioner's part should I fail to do so. I also understand that any illicit or sexually suggestive remarks or advances or any other inappropriate action made by me (the client/patient) will result in immediate termination of the session. I also understand all sessions must be paid in full at the end of each session. I understand that the massage therapist has the right to refuse service at any time or for any reason.

Print Name: _____

Signature: _____ **Date:** _____

Cancellation Notice Policy
Restoration Massage & Bodywork Therapies

Appointments will be given a reminder phone call the day before any appointment unless verbal acknowledgement is done on the previous visit (multiple session clients). Client must provide a phone # where they can be reached and/or a message may be left.

24 hour advanced notice must be received for massage therapy and a 48 hour advanced notice for Spa/Haven packages or a charge of 50% of total fees will be charged to the client (non-prepaid clients). All prepaid clients missed sessions will be charged the full prepaid session for the missed appointment. For non-prepaid fees, fees must be paid before another appointment may be made. If this is a medical case, this is not paid by insurance companies and is the responsibility of the client.

I _____(print name) understand the cancellation policy and accept responsibility for any fees for any session not cancelled within the acceptable time frame and agree to pay all fees associated with the missed appointment.

Signature: _____ Date: _____