

The Bodyworks Massage Center, Confidential Health History (Cont.)

DO YOU HAVE A HISTORY OF ANY OF THE FOLLOWING:

- | | | |
|--|--|--|
| <input type="checkbox"/> Accident | <input type="checkbox"/> Broken bones | <input type="checkbox"/> Colitis / IBS |
| <input type="checkbox"/> Anxiety or Depression | <input type="checkbox"/> Joint ache | <input type="checkbox"/> Asthma |
| <input type="checkbox"/> Arthritis, bursitis or gout | <input type="checkbox"/> Sciatica | <input type="checkbox"/> Tuberculosis |
| <input type="checkbox"/> Neck pain | <input type="checkbox"/> Sprains | <input type="checkbox"/> HIV / AIDS |
| <input type="checkbox"/> Whiplash | <input type="checkbox"/> Seizures | <input type="checkbox"/> Hepatitis |
| <input type="checkbox"/> Headaches | <input type="checkbox"/> Abdominal pain | <input type="checkbox"/> MRSA |
| <input type="checkbox"/> High blood pressure | <input type="checkbox"/> Nervous tension | <input type="checkbox"/> Staph Infection |
| <input type="checkbox"/> Shoulder pain | <input type="checkbox"/> Scoliosis | <input type="checkbox"/> Athletes Foot |
| <input type="checkbox"/> Upper back pain | <input type="checkbox"/> Osteoporosis | <input type="checkbox"/> Varicose veins |
| <input type="checkbox"/> Mid back pain | <input type="checkbox"/> Fibromyalgia | <input type="checkbox"/> Phlebitis |
| <input type="checkbox"/> Low back pain | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Blood clots |
| <input type="checkbox"/> Decreased range of motion | <input type="checkbox"/> Lyme Disease | <input type="checkbox"/> Stroke |
| <input type="checkbox"/> Carpal tunnel syndrome | <input type="checkbox"/> Spinal stenosis | <input type="checkbox"/> Heart attack |
| <input type="checkbox"/> Mastectomy | <input type="checkbox"/> Kidney Disease | <input type="checkbox"/> Lupus |
| <input type="checkbox"/> Breast Augmentation | <input type="checkbox"/> Cancer: _____ | <input type="checkbox"/> Surgery _____ |

PLEASE INDICATE YOUR CONSUMPTION LEVEL:

	None	Light	Moderate	Heavy
Salt:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Sugar:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Caffeine:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Tobacco:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Alcohol:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Exercise:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Water:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

OTHER: _____

ARE YOU BEING TREATED FOR ANY OF THE ABOVE CONDITIONS?

NO YES: _____

DO YOU HAVE ANY OF THE FOLLOWING TODAY?

- | | | |
|--|--|---|
| <input type="checkbox"/> Contact Lenses | <input type="checkbox"/> Inflammation | <input type="checkbox"/> Cold, flu, fever |
| <input type="checkbox"/> Dentures | <input type="checkbox"/> Irritated skin rash | <input type="checkbox"/> Headache |
| <input type="checkbox"/> Open cuts, bruises, burns | <input type="checkbox"/> Sunburn | <input type="checkbox"/> Severe pain |
| <input type="checkbox"/> Taken pain medication: | | |

OTHER: _____

WILL THIS BE YOUR FIRST MASSAGE? YES NO

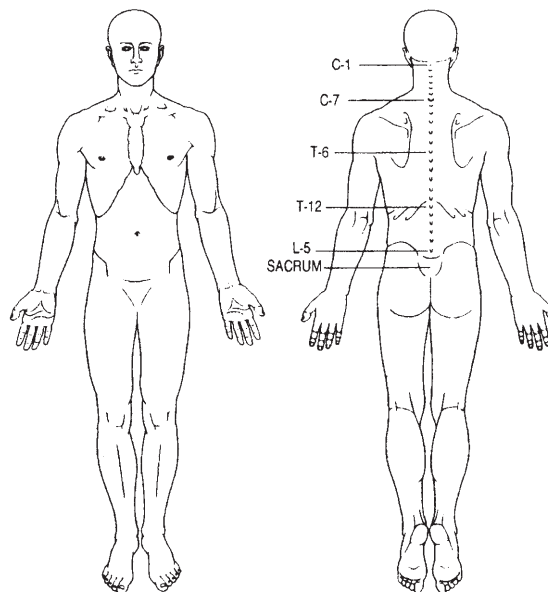
If NO, how long since your last massage? _____

WHAT ARE YOUR GOALS / EXPECTATIONS FOR TODAY'S SESSION?

PLEASE READ THE FOLLOWING AND SIGN BELOW:

I confirm that the above information is true to the best of my knowledge and understand that massage therapy is not a substitute for medical care and that no diagnosis will be made. I understand that payment is due when services are rendered and that I am responsible for paying for any missed appointment or appointment cancellation of less than 24 hours notice.

PLEASE INDICATE WITH AN (X) THE AREAS YOU ARE FEELING DISCOMFORT:



SIGNATURE

DATE

*PARENT / GUARDIAN Signature (if applicable)

Printed Name & Relationship

Date