

Confidential Client Health Information for Massage Therapy

Name _____ Social Security # _____

Address _____ City/State _____ Zip _____

Home Phone _____ Work Phone _____ Cell _____

DOB _____ Employer _____ Occupation _____

Referred By _____ Have you ever had a massage before? _____

Purpose for today's massage _____

List any medications you are taking: _____

Please check if you have any of the following conditions:

- | | |
|---|--|
| <input type="checkbox"/> Recent Injury | <input type="checkbox"/> Diabetes |
| <input type="checkbox"/> Recent Illness | <input type="checkbox"/> Kidney Problems |
| <input type="checkbox"/> Chronic Illness | <input type="checkbox"/> Recent Surgery |
| <input type="checkbox"/> Cancer | <input type="checkbox"/> Pregnancy |
| <input type="checkbox"/> Phlebitis | <input type="checkbox"/> Wear Contact Lenses |
| <input type="checkbox"/> High/Low Blood Pressure | <input type="checkbox"/> Skin Condition |
| <input type="checkbox"/> Allergies to Scents/Oils | <input type="checkbox"/> Blood Clots |
| <input type="checkbox"/> Varicose Veins | <input type="checkbox"/> Other _____ |

Please explain above _____

Are you currently under a doctor's care for any of the conditions above? _____

Name of Physician _____ Phone # _____

PRIVACY POLICY: Due to HIPAA Privacy Regulations, our office is required to offer you a notice of our privacy practices. This document lets you know what steps we take in protecting your health information. Please ask the front office staff if you would like a copy.

_____ Do not want a copy _____ Received a copy

Signature _____ Date _____

CANCELLATION POLICY

To avoid being charged a \$30 cancellation fee, I agree to give 24 hours notice.

Signature: _____ Date: _____