BODYWISE THERAPY

CLIENT HEALTH HISTORY

Name _________________________________ Date ___________ Birthdate ___________
Address _________________________ _ City _________________ State _____ Zip _____
Home Phone ______________ Cell Phone _____________ E-Mail __________________
Occupation ___________________ Work Responsibility ____________________________
Emergency Contact ____________________ Relationship _______ Phone ___________

CURRENT HEALTH

Have you ever received massage therapy before?____ Yes ____ No Frequency ______
Desired Pressure: ____ Light ____ Medium ____ Firm ____ Deep
Reason for today's visit: ____
Classify Concern: ____ Minor ____ Problematic ____ Major
Classify Type: ____ Recurring ____ Getting Worse ____ Getting Better
Desired Results: _______________________ Have you received treatment for this ____
Explain ____
Activities Affected ____
Exercise Activities ______________________________________ Frequency ___________
Current Medications ____

Check any that that apply to your current health:
___ Pregnant ___ Heart Conditions ___ Circulatory Issues ___ Blood Clots
___ Cancer ___ HIV/AIDS ___ Diabetes ___ Infections ___ Difficulty Breathing
___ Arthritis ___ Tense Muscles ___ Allergies ___ Blood Pressure (low/high)
___ Spinal injury
OTHER ____

MEDICAL HISTORY (List in chronological order, give dates and treatment received)
Surgeries ____
Accidents ____
Accidents ____
Major Illnesses ____

CONSENT FOR CARE

It is my choice to receive massage therapy, I am aware of the benefits and risks of massage and give my consent for massage. I understand that breast massage will at no time be a part of my therapy. I also understand that the effectiveness of individual techniques or series of sessions may vary. I acknowledge that massage therapy is not a substitute for medical care, examination or diagnosis. I have stated all of my known medical conditions and will inform my therapist of any changes in my health status. Signing by a parent or guardian below offers written consent for minors to receive massage therapy.

Client Signature _______________________________________ Date ___________________
(parent or Guardian for Minor)

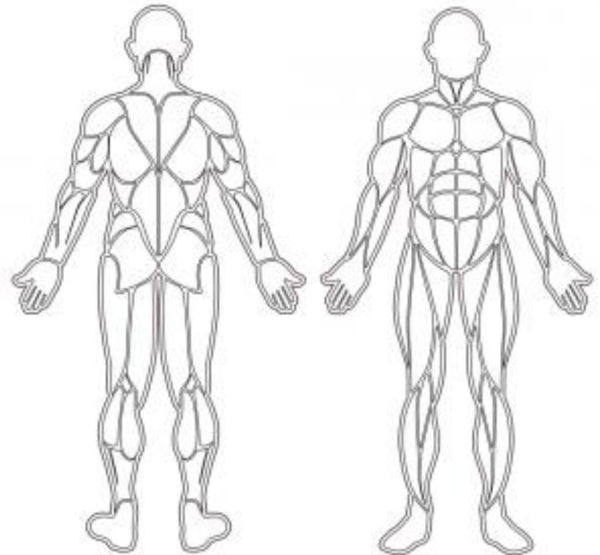
Therapist Signature ____________________________________ Date ___________________

BODYWISE
THERAPY

CLIENT ASSESSMENT FORM

To ensure that your time in therapy meets your specific needs, the following information will assist you and your therapist in achieving open communication and understanding about massage therapy.
Your therapy session may include the head, face, and neck, as well as the back, arms, legs and feet. Please take a moment to mark on the figures all areas of:

Pain and/or Tenderness with X's
Numbness and/or tingling with Z's
Swelling and/or Stiffness with O's
Scars, Bruises and/or open wounds with S's



Therapist Notes:

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- Massage Therapy in general is given to relieve stress and/or muscular tension, to enhance circulation and digestion, and promote over-all well being.
- Massage is not to be used in place of medical treatment
- The preceding health history is accurate and not withholding any medical needs or conditions.
- Any areas of concern regarding your health will be respected by the therapist during the session
- If for any reason you become uncomfortable within the session, the therapist will cease the therapy session
- The therapist will at all times maintain proper / appropriate draping during the therapy session
- If any health issues or modifications occur before future appointments, it is your responsibility to inform your therapist of such changes.
- NO SHOWS / LATE CANCELATIONS (within 24 hours) FOR SCHEDULED APPOINTMENTS YOU WILL BE RESPONSIBLE FOR FULL PRICE OF MISSED APPOINTMENT.

Client Signature ______________________________________ Date ___________________
(Parent or Guardian for Minor)

Therapist Signature ____________________________________ Date ___________________