HEALTH HISTORY FORM

FIRST NAME

LAST NAME

ISLAND FITNESS CANCELLATION POLICY

If you need to cancel your massage appointment, please do so 24 hours before your appointment. Appointments cancelled with less than 24 hours' notice will be billed at the full price of the missed massage. Billing of cancellations with less than 24 hours' notice due to illness or an emergency will be left to the discretion of the therapist. By signing this, you acknowledge our cancellation policy and agree to its terms.

SIGNATURE _____ DATE _____

PERSONAL DATA

Name _____

Date of Birth _____ referred by _____

Address _____

City _____

State _____ Zip _____

Phone Home / Cell _____

Phone Work / Cell _____

Occupation _____

Emergency contact _____

Phone _____

Primary health care provider _____

Location _____

Phone _____

Do you currently train? ☐ YES ☐ NO

Name of trainer _____

Location _____

Phone _____

What are your goals for receiving massage therapy? _____

_____

_____

"I give my massage therapist permission to contact and/or consult with my health care provider(s) and trainer(s) regarding my health and treatment."

INITIALS _____

LIST SELF-CARE ROUTINES

How do you reduce stress? _____

_____

Pain? _____

_____

Have you ever received massage therapy before?

☐ YES ☐ NO IF YES, FREQUENCY? _____

HEALTH INFORMATION

Health concerns. Check all that apply:

PRIMARY CONCERN _____

☐ mild ☐ moderate ☐ disabling

☐ symptoms increase with activity ☐ symptoms decrease with activity

☐ intermittent ☐ constant

☐ getting better ☐ getting worse ☐ no change

treatment received _____

SECONDARY CONCERN _____

☐ mild ☐ moderate ☐ disabling

☐ symptoms increase with activity ☐ symptoms decrease with activity

☐ intermittent ☐ constant

☐ getting better ☐ getting worse ☐ no change

treatment received _____

LIST DAILY ACTIVITIES LIMITED BY CONDITION

Work _____

_____

_____

Home/family _____

_____

_____

Sleep/self-care _____

_____

_____

Social/recreational _____

_____

_____

HEALTH HISTORY

List and explain. Where appropriate, include dates or general time frame and treatment(s) received.

MEDICATIONS _____

_____

_____

ALLERGIES _____

_____

_____

SURGERIES _____

_____

_____

MAJOR ILLNESSES _____

_____

_____

_____

INJURIES/ACCIDENTS _____

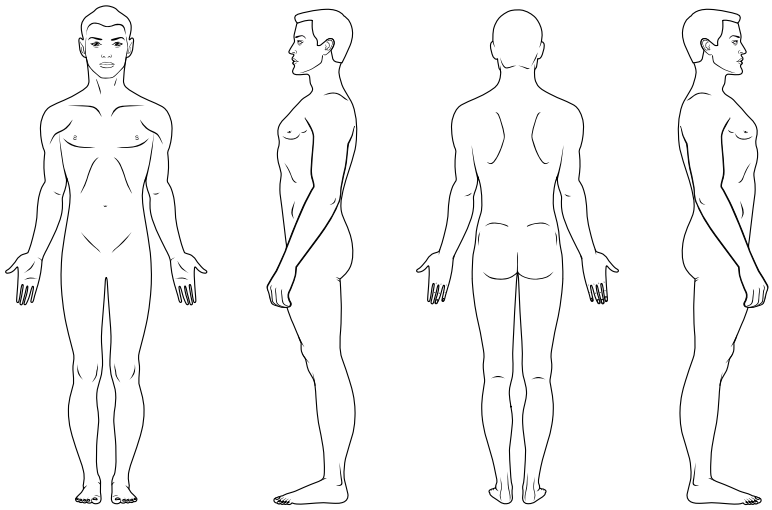
_____

_____

_____

PLEASE FILL OUT REVERSE >

INDICATE AREAS WHERE YOU ARE EXPERIENCING SYMPTOMS ON THE FIGURES • • •



Prioritize the areas of your body that you would prefer to be massaged. Mark with 1, 2, 3, etc., or "I would like full body massage, with attention paid to:" _____

_____

_____

_____

_____

_____

For which area(s) of your body do you give permission to receive massage? Check all that apply:

☐ back ☐ legs ☐ buttocks ☐ arms

☐ abdomen ☐ chest ☐ neck ☐ head

☐ face ☐ other _____

It is my choice to receive massage therapy. I realize that the treatment is being given for the well-being of my body and mind. This includes stress reduction, relief from muscular tension, spasm, or pain, or for the increasing circulation or energy flow. I agree to communicate with my practitioner any time I feel like my well-being is being compromised.

I understand that massage practitioners do not diagnose illness, disease, or any physical or mental disorder; nor do they prescribe medical treatment, pharmaceuticals, or perform spinal thrust manipulations. I acknowledge that massage is not a substitute for medical examination or diagnosis, and that it is recommended that I see a primary health care provider for that service.

I have stated all medical conditions that I am aware of and will update the massage practitioner of any changes in my health status.

_____

SIGNATURE DATE

FOR THERAPIST USE ONLY

REVIEWED BY CLIENT _____
initial *date*

REVIEWED BY CLIENT _____
initial *date*

NOTES:

I·S·L·A·N·D Fitness