Reflection Massage Therapy
Elly Krumrei L.M.T.
Health History Forms

This information listed below will assist us in treating you safely. Feel free to ask any question about the information being requested. Please note that all information below will be kept confidentially unless allowed by law. Your written permission will be required to release any information.

Assessment Date: ____/_____/_____
Name: _____Date of Birth____/_____/____
Phone Numbers (Home; Work; Cell) _____
Address: _____City: _____State: _____Zip: _____
Occupation: _____ Referred by: _____
Emergency Contacts (name and phone): _____
Have you received massage therapy before? (Yes / NO) If yes, what type? _____
Please list any areas you prefer not to be touched. _____
What is your main area of concern or pain? _____
Are you currently consulting the care of a health care practitioner? (Yes / No)
If yes, please provide their name and why. _____
Have you had any prior surgeries? When and what kind?_____
_____

To make your massage experience safer.

Have you consumed alcohol in the past 24 hours? (Yes/No)
Please list all medications including aspirin, vitamins and herbal remedies that you are currently taking._____

Please indicate conditions (C) for current, (P) for past and explain briefly

Musculoskeletal

___Bone or joint disease_____
___Broken/fractured bones_____
___Arthritis_____
___Tendonitis /Bursitis_____
___Lupus____Jaw pain____TMJ_____
___Sprains/strains_____
___Low back,hip,leg pain_____
___ Neck, shoulder, arm pain_____
___Headaches/ head injuries_____
___Spasms/cramps_____
___Pins/plates or surgical implants_____
Other _____

Skin

___ Allergies (nuts,seafood,latex)_____
___Rashes_____
___Athletes foot____Warts_____
Other_____

Digestive

___Constipation_____
___Gas /bloating_____
___ Celiac disease_____
___ Irritable bowel syndrome_____
___Abnormal pain_____
___Acid reflux/ hiatal hernia_____
Other_____

Endocrine/Reproductive

___Diabetes Type I _____
___Diabetes Type II _____
Level before and after massage _____/_____
___Pregnant? Stage_____
___ PMS_____
___ Epilepsy, date of last seizure_____
Other _____

Cardiovascular/Circulatory

___ High blood pressure, ____Low blood pressure
___Chronic congestive heart failure_____
___Heart attack_____
___Pacemaker or similar devise_____
___ Stroke/CVA_____
___Phlebitis/varicose veins_____
Other _____

Respiratory/ Infectious Disease

___ Asthma use of inhaler (Yes, No)
___Sinus problems_____
___Chronic cough_____
___ Bronchitis_____
___Shortness of Breath_____
___Emphysema_____
__ HIV /AIDS_____
___Herpes_____
___Hepatitis _____
Other_____

Nervous System/Urinary

___ Herpes/Shingles_____
___ numbness/ tingling_____
___ Chronic pain_____
___ Chronic Fatigue_____
___ Sleep disorders_____
___ Multiple Sclerosis_____
___Peripheral neuropathy _____
___ Nerve Compression_____
___Kidney/urinary infections_____
Other _____

Other Conditions and Family History:

Dentures/ Prosthetics_____ Hearing Aids_____; Wigs_____
Depression _____ Use of caffeine, nicotine, drugs, alcohol_____
Loss of sensations, Where? _____
Cancer/tumor_____

Please read carefully, Initial all spaces and sign.

Consent for Treatment If I experience any pain or discomfort during this session, I will immediately inform the practitioner so that the pressure and/or strokes may be adjusted to my level of comfort. Initials _____

I further understand that massage/bodywork should not be construed as a substitute for medical examination, diagnosis, or treatment and that I should see a physician, chiropractor, or other qualified medical specialist for any mental or physical ailment of which I am aware. I understand that massage/bodywork practitioners are not qualified to perform spinal or skeletal adjustments, diagnose, prescribe, or treat any physical or mental illness, and that nothing said in the course of the session given should be construed as such. Initials_____

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. I agree to keep the practitioner updated as to any changes in my medical profile and understand that there shall be no liability on the practitioner's part should I fail to do so. Initial _____

I also understand that any illicit or sexually suggestive remarks or advances made by me will result in immediate termination of the session, and I will be liable for payment of the scheduled appointment. Understanding all of this, I give my consent to receive care. Initials_____ Date:____/____/_____
Cancelations less than 24 hour notice and No show appointments will be subject to ½ the price of the appointment. Non-refundable payment in full is required before scheduling next appointment. _____

Client Signature: _____ Date: ___/___/____

Parent or Guardian Signature (in case of a minor): _____ Date: ___/____/____

Massage Therapist Signature_____Date:___/___/_____