Health History

OLIVE GROVE
THERAPY

CLIENT INFORMATION

Name _____

Date of Birth _____ Gender _____

Address _____

City _____ State _____ Zip_____

Home phone _____ Cell. Phone _____

Email address _____

Referred by (name & phone no.) _____ Occupation _____

EMERGENCY CONTACT

Name _____ Phone number_____

MASSAGE INFORMATION

Have you ever received professional massage/bodywork before? Y / N How recently? _____

What are your goals/expected outcomes for receiving massage/bodywork? _____

List and prioritize your current symptoms/issues (stress, pain, stiffness, numbness/tingling, swelling, etc.):

_____

_____

_____

Do these symptoms interfere with your activities of daily living (e.g., sleep, exercise, work, childcare)? Y / N Explain:

_____

_____

_____

List the medications you currently take:_____

_____

ARE YOU WEARING: contacts? Y / N | dentures? Y / N | a hairpiece? Y / N Are you pregnant? Y / N

Have you had any injuries or surgeries in the past? If yes, please explain: Y / N Explain:

_____

_____

_____

_____

CHECK ANY OF THE FOLLOWING HEALTH CONDITIONS THAT YOU **CURRENTLY** HAVE (IF YOU ARE UNSURE, PLEASE ASK):

CONDITION	CURRENT	PAST
BLOOD CLOTS		
INFECTIONS		
CONGESTIVE HEART FAILURE		
CONTAGIOUS DISEASES		
PITTED ADEMA		

PLEASE ANSWER HONESTLY, AS MASSAGE MAY NOT BE INDICATED FOR THE ABOVE CONDITIONS. PLEASE INDICATE CONDITIONS THAT YOU HAVE OR HAVE HAD IN THE PAST. EXPLAIN IN DETAIL, INCLUDING TREATMENT RECEIVED:

CONDITION	CURRENT	PAST	EXPLAIN
MUSCLE OR JOINT PAIN			
MUSCLE OR JOINT STIFFNESS			
NUMBNESS OR TINGLING			
SWELLING			
BRUISE EASILY			
SENSITIVE TO TOUCH/PRESSURE			
HIGH/LOW BLOOD PRESSURE			
STROKE/HEART ATTACK			
VARICOSE VEINS			
SHORTNESS OF BREATH, ASTHMA			
CANCER			
NEUROLOGICAL (E.G. MS, PARKINSON'S, CHRONIC PAIN)			
EPILEPSY, SEIZURES			
HEADACHES, MIGRAINES			
DIZZINESS, RINGING IN THE EARS			

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CONDITION	CURRENT	PAST	EXPLAIN
DIGESTIVE CONDITIONS (E.G. CROHN'S, IBS)			
GAS, BLOATING, CONSTIPATION			
KIDNEY DISEASE, INFECTION			
ARTHRITIS (RHEUMATOID, OSTEOARTHRITIS)			
OSTEOPEROSIS, DEGENERATIVE SPINE/DISK			
SCOLIOSIS			
BROKEN BONES			
ALLERGIES			
DIABETES			
ENDOCRINE/THYROID CONDITIONS			
DEPRESSION, ANXIETY			
MEMORY LOSS, CONFUSION, EASILY OVERWHELMED			

COMMENTS: _____

_____

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. 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. 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. 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.

Client signature: _____ Date: _____

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