Confidential Client Information And Health History

SpaTyler.com Karin Honea,

Full Name: _____
Address: _____ City: _____ State: _____ Zip: _____
Phone (Home): _____ (Work):_____ (Cell): _____
Date of Birth:_____ Age: _____ Employer: _____
Occupation:_____ Emergency Contact: _____
Phone: _____Relationship: _____ Referred by: _____
Marital Status: _____ **Email:** _____
How did you hear about us? __ Our website __ Internet __ Newspaper Ad __ Yellow Pages __
Family/Friend? (Who: _____ Other _____ Is this your first professional massage? _____ If no, how frequently do you get a massage? _____ What do you hope to accomplish from today's message? _____
Are you aware of any tension holding spots in your body? ____ If yes, location(s) _____
_____
Describe any surgeries, hospitalizations, accidents or injuries you have had in the last 10 years: _____
_____
What kind of care did you receive for your accidents or injuries? _____
Do you feel that you have recovered from these events? _____ Please explain: _____
Do you have any chronic, ongoing pain that you deal with on a regular basis? _____ Please explain: _____
_____
Describe what activities cause this pain and or makes it worse: _____
Are you receiving any other type of medical treatment? _____ Please explain: _____
Please list any medication (vitamins, herbs or pharmaceutical) taken now or at regular intervals (include explanation of what medication is used to treat): _____
_____
Are you currently under the care of a physician?_____ Whom? _____
Please list reason(s): _____
Are there any other health concerns you wish to discuss today? Yes / No If yes, please describe:
_____
Are you currently experiencing any of the following conditions? ____Flu or Cold ____Inflammation ____Fever ____Infection ____Contagious Disease ___ Other _____
Please check any of the following conditions below that currently affect you or that you have experienced in the last 10 years**.** **Circle if condition checked is being experienced now.**

Musculoskeletal
___ Arm/ Shoulder Pain
___ Bursitis
___ Carpal Tunnel Syndrome
___ Cysts
___ Fibromyalgia
___ Gout
___ Headache
___ Hip Pain
___ Leg Pain
___ Low Back Pain
___ Mid Back Pain
___ Osteoporosis
___ Osteoarthritis/Rheumatoid
___ Plantar Fasciitis
___ Postural Deviations
___ Sciatica
___ Scleroderma
___ Spasms / Cramps
___ Sprains / Strains
___ Tendonitis
___ Thoracic Outlet Syndrome
___ TMJ Dysfunction

Circulatory
___ Anemia
___ Blood Clots / Phlebitis
___ Diabetes
___ Heart condition
___ Hemophilia
___ Hypertension
___ Low blood pressure
___ Raynaud's Disease
___ Varicose Veins
___ Other

Digestive
___ Colitis
___ Crohn's Disease
___ Diarrhea
___ Gallstones
___ Gas / Bloating
___ Hepatitis
___ Indigestion / GERD
___ Irritable Bowel Syndrome
___ Ulcers
___ Other

Nervous System
___ ALS
___ Bell's Palsy
___ Multiple Sclerosis
___ Neuritis
___ Numbness/Tingling/Twitch
___ Parkinson's Disease
___ Seizure Disorders
___ Spinal Cord Injury
___ Stroke
___ Trigeminal Neuralgia
___ Other

Other
___ Anxiety/Panic Attacks
___ Bladder Infection
___ Cancer (Stage: 1, 2, 3, 4)
___ Chronic Fatigue
___ Edema
___ Grief Process
___ HIV / AIDS
___ Insomnia
___ Kidney Disease
___ Lupus

___ Torticollis
___ Whiplash Syndrome
___ Other

Respiratory

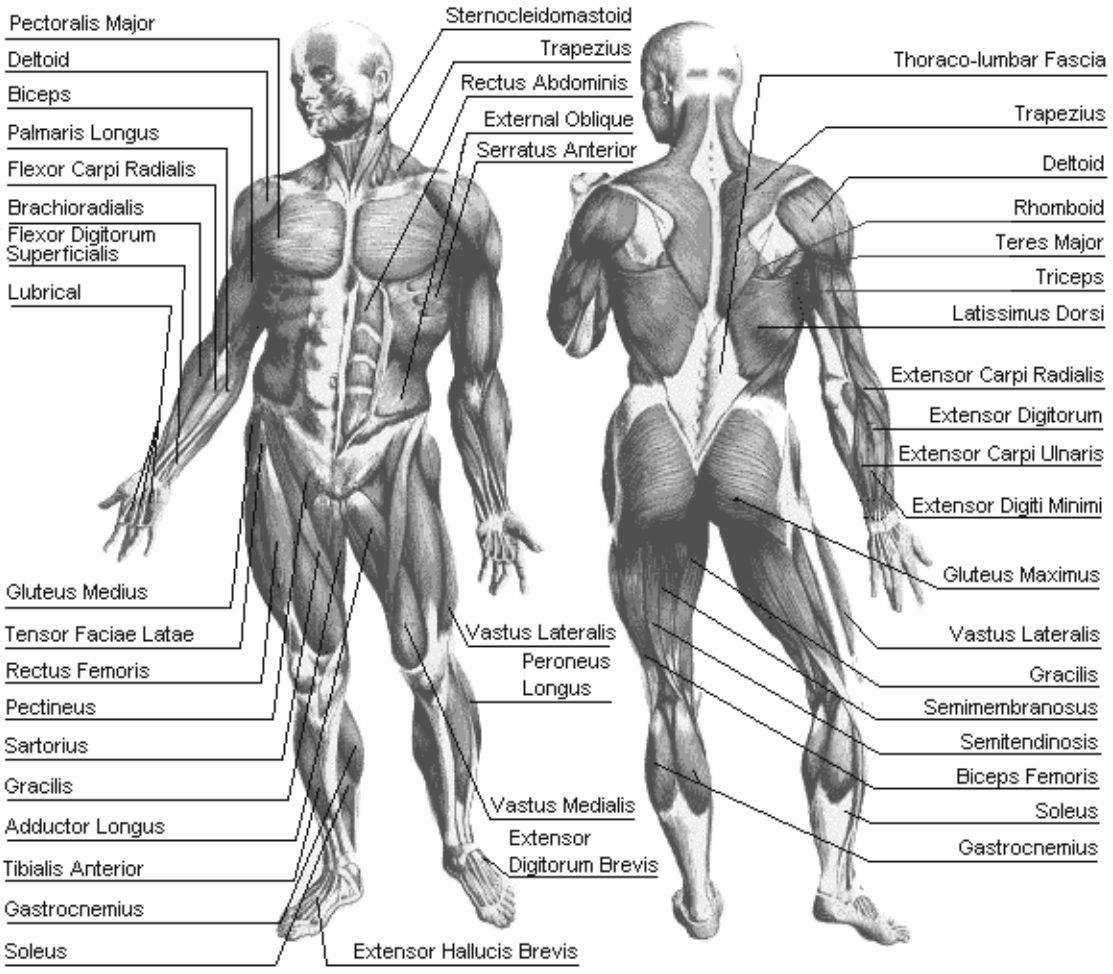
___ Asthma
___ Dizziness
___ Oxygen (liters: _____)
___ Pneumonia
___ Sinusitis

Skin

___ Athletes Foot
___ Dermatitis/Eczema
___ Fungal Infections - Acne
___ Impetigo
___ Psoriasis
___ Open Wound or Sore
___ Rashes
___ Warts / Moles

___ Trouble Breathing
___
___ Postoperative Situation
___ Sleep Apnea
___ PMS
___ Substance Abuse
___ Other
___ _____
___ _____

Please CIRCLE the area or areas where you experience pain or discomfort on the drawing below:



The above information is accurate and true to the best of my knowledge. I understand that massage therapists do not diagnose disease, prescribe medications, or manipulate bones. I further understand that massage therapy is not a substitute for medical attention or examination. I take responsibility for alerting my practitioner to any physical, mental, or emotional changes that occur with my health. I also understand that cancelled or missed appointments without 24 hours notice (medical emergencies excluded) will be charged in full for the price of the missed session. If I have requested a full body massage I acknowledge that everything except front lower genital region may be massaged as discussed with my therapist.

Signature: _____ Date:_____