

Henderson Wellness Center
Client History for Massage Therapy

NAME: _____ DATE: _____ SEX: M / F _____ MARTIAL STATUS: _____

ADDRESS: _____

CITY/ STATE/ZIP: _____ BIRTHDAY: _____

BEST CONTACT #:() _____ OK TO TEXT? YES / NO
(FOR CONFIRMATIONS OR APPT CHANGES)

EMERGENCY NAME AND NUMBER: _____

OCCUPATION: _____ PHYSICAL LABOR ASSOCIATED WITH YOUR JOB?
YES / NO / OCCASIONAL

ARE YOU CURRENTLY OR HAVE YOU EVER BEEN A PATIENT AT HENDERSON WELLNESS CENTER? _____

HOW DID YOU FIND US?
(IF YOU WERE REFERRED BY AN EXISTING CLIENT THEY GET A DISCOUNT ON THEIR NEXT HOUR MASSAGE)

HAVE YOU HAD MASSAGE BEFORE? _____

WHAT TYPE OF TOUCH DO YOU PREFER? (Circle all that apply)
Light: (surface touch) / Firm: (like applying lotion) / Moderate: (impacts muscles) /
Deep Tissue: (targets problem areas) / Not sure .

ARE YOU CURRENTLY RECEIVING MEDICAL TREATMENT THAT WOULD EFFECT YOUR MASSAGE? _____

DO YOU CURRENTLY TAKE BLOOD THINNING MEDICATION (INCLUDING ASPIRIN OR ARTHRITIS MEDICATION)? _____

PLEASE CIRCLE ANY THAT APPLY:

Heart or circulation problems	Epilepsy/seizures	Dizziness/vertigo
High blood pressure	Psoriasis/ skin disorder	Fibromyalgia
Varicose veins	Numbness/tingling	Depression/anxiety
Diabetes	Cancer	History stroke/TIA
Broken bones	Disc rupture/bulge	

Have you had a fever of 100 degrees or higher in the last 24 hours? _____

PLEASE TAKE A MOMENT TO CAREFULLY READ AND SIGN THE FOLLOWING INDICATING YOU HAVE READ AND AGREE:

I understand that the massage / bodywork I receive is provided for the basic purpose of relaxation and relief of muscular tension. I understand that there are some medical conditions or specific symptoms, massage / bodywork may be contraindicated. A referral from a primary care provider may be required. 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 I understand that there shall be no liability on the practitioner's part should I fail or forget to do so. I further understand that massage/ bodywork should not be construed as a substitute for medical examinations, diagnosis, or treatment and that I should see a physician, chiropractor or other qualified medical specialist for any mental or physical ailments that I am aware of. I understand that massage/ bodywork practitioners are not qualified to perform spinal or skeletal adjustments, diagnose, prescribe or treat any physical or mental illness. Nothing said in the course of the session given should be construed as such. If I experience any pain or discomfort during the session , I will immediately inform the practitioner so that pressure and / or strokes may be adjusted to my comfort level, as I can not assume that the practitioner can read my mind or understand my facial expressions. **It is also understood 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 session in full.**

CLIENT'S SIGNATURE: _____ DATE: _____