HMH Wellness Center, Inc. Client Information Form

Name:______________________________ **Date of Birth:**______________________

Address:______________________________ **Telephone:**______________________

City:______________________________ **State:**__________ **Zip:**______________

Occupation:______________________________ **Employment:**______________________

Referred by:______________________________ **E-Mail:**______________________

In Case of Emergency:______________________ **Telephone:**______________________

GENERAL & MEDICAL INFORMATION - Circle

Yes No Have you ever experienced a professional massage before? How long ago?____________
Yes No Do you bruise easily?
Yes No Do you frequently suffer from stress?
Yes No Do you experience frequent headaches?
Yes No Do you have varicose veins or blood clots? If so Where?____________________
Yes No Do you suffer from arthritis?
Yes No Do you have difficulty relaxing?
Yes No Do you have problems falling to sleep at night?
Yes No Do you have high or low blood pressure? If so, which?____________________
Yes No Do you have any contagious or infectious diseases?____________________
Yes No Do you have any heart problems? Please explain____________________
Yes No Do you have tension or soreness in a specific area?____________________
Yes No Do you have numbness or stabbing pains anywhere?____________________
Yes No Do you suffer from back pain?
Yes No Are you sensitive to touch or pressure in any area?____________________
Yes No Are you allergic to any types of oils or lotions?____________________
Yes No Are you pregnant? If so, how many weeks?____________________
Yes No Have you had any broken bones in the past two years?____________________
Yes No Have you been in an accident or suffered any injuries in the past two years?____________
Yes No Do you have any other medical conditions we should know about?____________________

CONDITIONS DIAGNOSED BY A PHYSICIAN – Circle if current, check if treated in the past

______Diabetes ______Nervous Breakdown ______Depression
______Migraine headaches ______Carpal Tunnel Syndrome ______Cancer
______Bursitis ______Ulcer ______Fibromyalgia
______Sciatica ______Arthritis ______Torn Rotator Cuff(s)
______Other____

Please take a moment to carefully read the following information and sign where indicated. If you have a specific medical conditions or specific symptoms, massage/bodywork may be contraindicated. A referral from you primary care provider may be required prior to service being provided.

I understand that the massage/bodywork I receive is provided for the basic purpose of relaxation and relief of muscular tension. 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 or bodywork should not be construed as a substitute for medical examination, diagnosis, or treatment and that I should see a physician or other qualified medical specialist for any mental or physical ailment 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, 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 forget to do so. 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 scheduled appointment.

Client Signature______________________________ Date______________________________

Client Update

Client Name:____

Session Date:______________________Time:____________Length of Session:____________

Physical Complaints:____

Notes:____MT______________

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Session Date:______________________Time:____________ Length of Session:____________

Physical Complaints:____

Notes:____MT______________

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Session Date:______________________Time:____________ Length of Session:____________

Physical Complaints:____

Notes:____MT______________

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