Client Health History

Full Name _____ Birth date _____

Full Address_____

Email_____

Telephone _____Text ok?_____

Occupation _____

Describe your exercise _____

_____

Describe your diet_____

Do you have allergies? _____

Do you have skin conditions?_____

Do you take medications?_____

Please List any previous illnesses, injuries or surgeries:

Muscular (include strains/stiffness)_____

_____

Skeletal (include breaks/sprains)_____

_____

Head Injury/TMJD/Orthodonture_____

_____

Circulatory_____

_____

Respiratory_____

_____

Digestive_____

_____

Nervous_____

_____

Reproductive/Urogenital_____

_____

Infectious Disease _____

_____

Cancer_____

Explain your treatment and any lasting effects:_____

_____

Have you received Craniosacral (CST) or massage therapy (MT) before? Y_____ N_____

Which, and how often?_____

What did you like?_____

What didn't you like?_____

What would you like to gain from receiving CST/MT today, and in sessions to come?

_____

_____

How have you been feeling?_____

_____

If you feel stress, pain, tenderness, numbness, weakness or inflammation please tell me where:_____

_____

_____

Where do you want special attention, and what is sensitive to touch? (breasts and genitals are never touched) :

_____

_____

_____

_____

I realize that the treatment is being given for the well-being of my body and mind. This includes stress reduction, relief from muscular tension, spasm or pain, treatment of injury, or for increasing circulation. I agree to inform my massage therapist any time I feel that my well-being is being compromised.

I understand that massage therapists do not diagnose illness or any mental disorder; nor do they prescribe medical treatment. I acknowledge that massage is not a substitute for medical examination or diagnosis, and that it is recommended I see a primary health care provider for that.

I have stated all pertinent medical conditions that I am aware of and will update the massage therapist of any changes my health status. I understand that these health records are confidential, and I authorize Susanne E. Ashland, as my massage therapist, to contact my health care providers if necessary.

In addition, if necessary, I authorize Susanne E. Ashland, as my massage therapist, to release any medical records to insurance or legal representatives for billing purposes. I understand and agree to the fees and billing policies of Susanne E. Ashland, LMT, CCST.

I 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.

I need to provide Susanne E. Ashland at least 24 hours' notice in order to reschedule or cancel an appointment, otherwise I will be charged for the missed session. If I fail to show up for my appointment I will be charged for the missed session and may be asked to pre-pay for future appointments.

If I arrive late for my appointment Susanne E. Ashland will give me as much time as she can. This will be at her discretion and based on the needs of her schedule. The full appointment fee will nonetheless be charged.

Signature & Date _____