Confidential Client History

MH VICARS SCHOOL *of* MASSAGE THERAPY

Name Birth date (m/d/yy)

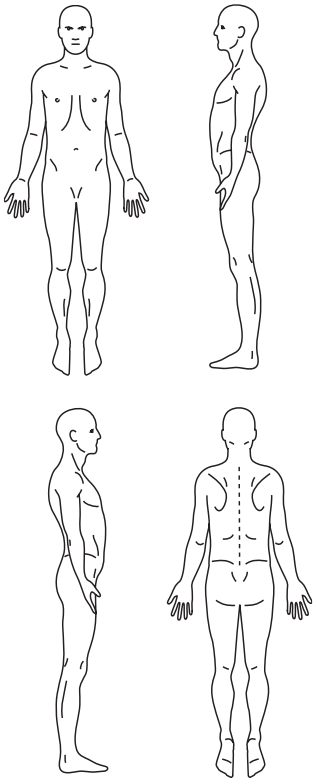
Address City Postal Code

Phone Cell

Email

Gender Height Weight Today's date

Please indicate (with a circle) on the diagram where you are experiencing any soreness or problems:



General

Occupation

Sports

Hobbies

Describe your sleep patterns

Do you have difficulty lying in a certain position?

List surgeries in the last 5 years

List any serious or lasting trauma

Explain any other health or medication information

Have you had massage before?
Yes / No (Please circle)

What was your experience?

Are you receiving treatment from any other health care professional?

❑Physician ❑Chiropractor
❑Physical Therapist ❑Acupuncture
❑Naturopath ❑Other:

Indicate conditions currently or recently experienced

Infectious Conditions (present today)

❑ Skin *(rash, warts, open sores, herpes, or similar)*
❑ Respiratory *(common cold, bronchitis)*
❑ Systemic *(hepatitis, HIV/AIDS, flu or similar)*

Medications taken for these conditions

Comments

Skin Conditions (non-contagious)

❑ Eczema ❑Psoriasis ❑ Contact allergies

List medications taken for these conditions

Comments

Please inform your therapist if you are currently experiencing a "flare-up" of any infectious condition.

Continued on next page

Indicate conditions currently or recently experienced (continued)

Cardiovascular

- ❑ High blood pressure
- ❑ Phlebitis
- ❑ Low blood pressure
- ❑ Stroke
- ❑ Chronic congestive heart failure
- ❑ Heart attack
- ❑ Varicose veins *(not spider veins)*
- ❑ Heart disease *(heart valve, pacemaker or similar device)*

List medications taken for these conditions

Comments

Head and Neck

- ❑ History of stress headache
- ❑ Vision problems
- ❑ History of migraine headache
- ❑ Ear problems
- ❑ Hearing loss
- ❑ Dizziness
- ❑ Vision loss

List medications taken for these conditions

Comments

Respiratory

- ❑ Asthma
- ❑ Bronchitis
- ❑ Emphysema
- ❑ Chronic cough
- ❑ Shortness of breath
- ❑ Allergies

List medications taken for these conditions

Comments

Muscle/Joint/Bone

- ❑ Rheumatoid arthritis
- ❑ Scoliosis
- ❑ Fractures/sprains
- ❑ Osteoporosis
- ❑ Wires/plates/pins
- ❑ Osteoarthritis

List medications taken for these conditions

Comments

Digestive

- ❑ Crohn's disease
- ❑ Constipation
- ❑ Colitis
- ❑ Ulcers
- ❑ Liver disease
- ❑ IBS

List medications taken for these conditions

Comments

Women

- ❑ Pregnancy Due date: _____
- ❑ Pregnancy complications
- ❑ Menstrual problems
- ❑ Menopausal problems
- ❑ Gynecological problems

List medications taken for these conditions

Comments

Other Conditions

- ❑ Diabetes
- ❑ Epilepsy
- ❑ Cancer
- ❑ Hemophilia
- ❑ Fibromyalgia
- ❑ Chronic fatigue
- ❑ Kidney disease
- ❑ Polio/Post-polio

List medications taken for these conditions

Comments

Waiver

I,_____,
release the massage practitioner from any and all liability from problems arising from the treatment as a result of information not given, or incorrectly given in this patient history. Because my personal and medical information is confidential, I understand that this information will be seen only by the student and instructor, unless I give my consent in writing.

I understand that the practitioner is a student, and that their practice is limited to their scope of learning at this time.

Signature