



oneness through wellness

## CONFIDENTIAL CLIENT INFORMATION AND HEALTH HISTORY

First Name: \_\_\_\_\_ Last Name: \_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Phone(h): \_\_\_\_\_ (cell) \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Occupation: \_\_\_\_\_ Email: \_\_\_\_\_

Emergency contact name phone: \_\_\_\_\_

Referred by \_\_\_\_\_

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Is this your first professional massage? \_\_\_\_\_ How frequently do you get a massage? \_\_\_\_\_

What do you hope to accomplish from today's session? \_\_\_\_\_

Are there areas of tension/strain that need focused attention?

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Describe any surgeries, hospitalizations, **accidents or injuries** you have had:

Less than 5 years ago: \_\_\_\_\_

More than 5 years ago: \_\_\_\_\_

What kind of care did you receive for your accidents or injuries? \_\_\_\_\_

Do you have any **chronic, ongoing pain** that you deal with on a regular basis? \_\_\_\_\_

Describe what activities cause this pain and/or make it worse: \_\_\_\_\_

Are you receiving any other type of medical treatment? \_\_\_\_\_

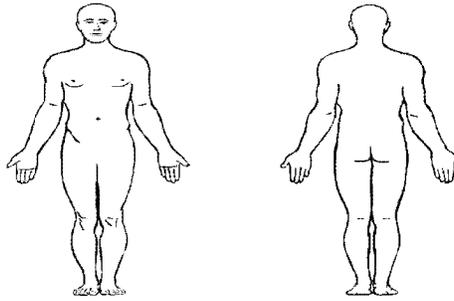
Please list any medication (vitamins, herbs or pharmaceutical) taken now or at regular intervals: \_\_\_\_\_

Are you currently under the care of a physician? \_\_\_\_\_ Whom? \_\_\_\_\_

Please list reason(s): \_\_\_\_\_

Are you currently experiencing any of the following conditions?

\_\_\_\_\_ Flu or Cold      \_\_\_\_\_ Inflammation      \_\_\_\_\_ Fever      \_\_\_\_\_ Infection      \_\_\_\_\_ Contagious Disease



**MUSCULOSKELETAL**

- Fibromyalgia
- Spasms/Cramps
- Sprains/Strains
- Osteoporosis
- Postural Deviations
- Gout
- Osteoarthritis/Rheumatoid Arthritis
- TMJ
- Cysts
- Bursitis
- Plantar Fasciitis
- Tendonitis
- Torticollis
- Whiplash Syndrome
- Carpal Tunnel Syndrome
- Sciatica
- Thoracic Outlet Syndrome
- Headache
- Leg Pain
- Arm Pain/Shoulder Pain
- Low Back Pain
- Mid Back Pain
- Hip Pain
- Other \_\_\_\_\_

**RESPIRATORY**

- Pneumonia
- Sinusitis
- Asthma
- Trouble Breathing
- Dizziness
- Other \_\_\_\_\_

**CIRCULATORY**

- Anemia
- Hemophilia
- Hypertension
- Low Blood Pressure
- Raynaud's Disease
- Varicose Veins
- Heart Condition
- Blood Clots/Phlebitis
- Diabetes
- Other \_\_\_\_\_

**DIGESTIVE**

- Ulcers
- Irritable Bowel Syndrome
- Colitis
- Gallstones
- Hepatitis
- Crohn's Disease
- Diarrhea
- Gas/Bloating
- Indigestion
- Other \_\_\_\_\_

**SKIN**

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

**NERVOUS SYSTEM**

- ALS
- Multiple Sclerosis
- Parkinson's Disease
- Bell's Palsy
- Neuritis
- Spinal Cord Injury
- Stroke
- Trigeminal Neuralgia
- Seizure Disorders
- Numbness/Tingling/Twitching
- Other \_\_\_\_\_

**OTHER**

- Insomnia
- Anxiety/Panic Attacks
- PMS
- Grief Process
- Cancer
- Substance Abuse
- Pregnancy
- Chronic Fatigue
- HIV/AIDS
- Lupus
- Kidney Disease
- Bladder Infection
- Postoperative Situation
- Edema
- Other \_\_\_\_\_

I understand that massage therapy given here is for the purpose of stress reduction, relief from muscular tension or spasm or for increasing circulation and energy flow. I understand that Rhianna Sanford does not diagnose illness, disease or any other physical or mental disorder. As such, Rhianna Sanford does not prescribe medical treatment or pharmaceuticals, nor perform any spinal manipulations. It has been made very clear to me that massage therapy is not a substitute for medical examinations and/or diagnosis and that it is recommended that I see a physician for any physical ailment that I might have.

Because a massage therapist must be aware of existing physical conditions, I have stated all my known medical conditions and take it upon myself to keep Rhianna Sanford updated on my physical health. Given the above, I understand that response to treatment varies on an individual basis and that specific results are not guaranteed. Therefore, in consideration for any treatment received, I agree to hold harmless and release from any liability Rhianna Sanford of Namaste Therapies, LMT, for any condition or result, known or unknown that may arise as a consequence of any treatment that I receive.

Print name: \_\_\_\_\_ Signature: \_\_\_\_\_

Practitioner Signature: \_\_\_\_\_ Date: \_\_\_\_\_

