Massage & Bodywork Health History Form

Name: Address:
Pronouns:

Daytime Contact # Occupation
Evening Contact # Birthday

In case of emergency, please notify: Name
Telephone #

How did you hear about DelicateEssence?
What would you like to achieve from your treatment today?

Have you ever had professional massage? Yes No

Are you currently under chiropractic/holistic treatment? Yes No
How long ago? _____ How often? _____

Areas of concern currently or in the past…

Musculo-Skeletal System
___Osteoporosis
___Broken/Fractured Bones
___Arthritis
___Sprains/Strains
___Back Pain
___Head Injuries
___Spasms/Cramps
___TMJ Disorder
___Other

Circulatory/Respiratory System
___Heart Condition
___Varicose Veins
___High/Low Blood Pressure
___Blood Clots
___Breathing Difficulty
___Asthma
___Sinus Problems
___ Allergies
___Other

Skin
___Allergies
___Psoriasis
___Rashes
___Warts
___Fungus
___Other

Digestive System
___Abdominal Pain
___Nausea
___Bloating
___Irritable Bowel Syndrome
___Other

Female Reproductive System
___Pregnant?
How many times?
Now? If so, how many weeks?_____
Due date?_____
___PMS
___Endometriosis
___Other

Nervous System
___Headaches
___Numbness/Tingling, and if so, where?
___Fatigue
___Sleeping Disorders
___Depression
___Other

Miscellaneous
___Teeth Clenching
___Fibromyalgia
___Diabetes
___Surgery, and if so, when and where?

___Accidents or injuries, and if so, when and where?

___Cancer/Tumors, and if so, when and where?

___Other

Please list medications and their purpose:

Are there any other health concerns that your therapist should be aware of?

I understand that massage therapy provided by DelicateEssence LLC is intended to enhance relaxation, reduce pain caused by muscle tension, increase range of motion, improve circulation and offer a positive experience of touch. The general benefits of massage, possible massage contraindications and the treatment procedure have been explained to me. I understand that massage therapy is not a substitute for medical treatment or medications, and that it is recommended that I concurrently work with my Primary Care Provider for any condition I may have. I am aware that the massage therapist does not diagnose illness or disease, does not prescribe medications, and that spinal manipulations are not a part of massage therapy. I further understand that any sexual innuendo, propositioning or touch will result in immediate termination of the session with payment due in full. I have informed my massage therapist of all my known physical conditions, medical conditions and medications, and I will keep the massage therapist updated on any changes. I will still be responsible for the full payment of the session scheduled if I cancel within 24 hours of the appointment, except in the case of an emergency.

Client Signature:_____
Date_____

*Consent to Treatment of Minor: By my signature below I hereby authorize massage/bodywork techniques to be administered to my child or dependant, as is deemed necessary.

Signature:_____
Date_____