HEALTH HISTORY

Name: _______________________________________ D.O.B. _________ Age: ________ Today's Date: _________________

Address: _______________________________________ City: ______________________ State: ______ Zip: ______________

Best Number To Reach You: ☐ Cell ☐ Work ☐ Phone: _____________________ Email*: _______________________________

Occupation: ____________________________ Activities at work: ____

Emergency Contact: ______________________________ Phone: __________________ Relationship: ______________________

Your email is confidential and never sold. By sharing your email you will receive appointment confirmations and a monthly FitBody Studio specials & health tips.

How did you hear about us? ____

1. Why are you coming for massage? ____

2. Do you want a full body massage? _________ List any specific areas that need focus? _____________________________________

3. Please select any of the following that might apply:

- ❑ Allergies, which: _________________________________
- ❑ Arthritis, where: __________________________________
- ❑ Cancer __ Current; __ Latent. Type: ________________
- ❑ Diabetes
- ❑ Diseases/Current Diagnosis: _______________________
- ❑ Edema, where: _____________________________________
- ❑ Headaches
- ❑ High Blood Pressure/Heart Condition
- ❑ Infectious Condition: __ HIV/AIDS __ TB __ Hepatitis
- ❑ Medications: ____
  (use back of form to list additional medications)
- ❑ Open sores, where: _________________________
- ❑ Phlebitis/Blood Clots, where: _________________
- ❑ Poor Circulation
- ❑ Pregnant, what month? _____
- ❑ Recent Change in Weight
- ❑ Respiratory Condition: ______________________
- ❑ Skin Condition: ___________________________
- ❑ TMJ
- ❑ Varicose Veins
- ❑ Wear Contacts

4. Please explain recent or past accidents/injuries/surgeries/diagnosis? (use back of form to list additional)
A) Explain: ____

____ When? _________

Have you had any of the following symptoms since the explained incident?

- ❑ Blurred/Double Vision
- ❑ Dizziness/Fainting
- ❑ Swelling, where: __________
- ❑ Trouble Talking
- ❑ Ringing in Ear
- ❑ Headache

5. What are your current stress/tension factors? ____

6. What are your exercise habits? What type of activities? ____

____ How often per week? _______________

7. **Massage Therapy Information**
a) Last date you received a massage? ________________
b) Massage Therapy Preference: ____ Relaxation (Swedish) ____ Relaxation w/Therapeutic Pain Relief
c) Pressure: ___ Light ___ Moderate ___ Deep

I certify that the above information is complete and correct. I will keep the massage therapist informed of any changes as they occur. I will be responsible for financial payments and for any scheduled appointment, which is not canceled 24 hours in advance. I understand that neither the therapist nor FitBody, LLC will be liable for any injuries or loss sustained to myself or property. In addition the therapist and staff disclaims responsibility for injury sustained during exercises or stretches given to perform. I will not begin exercises or stretches without first consulting my physician for advice.

Client Signature:

OFFICE USE	Preferences: Avoid:	❑ Card Delivered