Confidential Client Health History Form

Date: ____________

Name: ______________________________ Date of birth: ________

Age: ________ Height: ________ Weight: ________ Occupation: ____________________

Address: ______________________________ City: ____________________ State: ______ Zip: ________

Home Phone: ____________________ Business Phone: ____________________

Cell Phone: ____________________ E-mail: ____________________

Physician: ____________________ Phone: ____________________

Emergency Contact: ____________________ Phone: ____________________

How did you find us?: ______________________________

Your Health

1) Have you been under the care of a physician, dermatologist or other medical professional within the past year?

☐ No ☐ Yes, explain: ______________________________

2) Any recent surgery, including plastic surgery? ☐ No ☐ Yes, explain:

____

3) Any skin cancer? ☐ No ☐ Yes, explain: ______________________________

4) Have you had any piercings, tattoos, or permanent cosmetics? ☐ No ☐ Yes, If yes, where on your body?

____

5) When was your last facial ______ massage ______ or body treatment? ____________________

Where ____________________?

6) Have you had any of these health conditions in the past or present?

(Please check all that apply and provide additional information in the space provided
Please circle of you have any of these issues TODAY)

Condition		Condition	
Cancer	☐	Headaches (chronic)	☐
Hormone imbalance	☐	Hepatitis	☐
Systemic disease	☐	Herpes	☐
High blood pressure	☐	Frequent cold sores	☐
Spinal injury	☐	Immune disorders	☐
Thyroid condition	☐	HIV/AIDS	☐
Hysterectomy	☐	Lupus	☐
Diabetes	☐	Metal bone pins or plates	☐
Heart problem	☐	Phlebitis, blood clots, poor circulation	☐
Varicose veins	☐	Blood clotting abnormalities	☐
Arthritis	☐	Psychological treatment	☐
Asthma	☐	Insomnia	☐
Eczema/Psoriasis	☐	Keloid scarring	☐
Epilepsy	☐	Skin disease/skin lesions	☐
Seizure disorder	☐	Any active infection	☐
Fever blisters	☐	Skin rash/poison ivy/irritation	☐
Severe pain	☐	Musculoskeletal problems	☐
Sunburn	☐	Cold or flu	☐
Hernia	☐	stomach ulcers	☐
Hemophilia	☐	Inflammation	☐
Cuts/Burn/Bruising	☐		
Dizziness	☐		

Confidential Client Health History Form—continued

7) Has your physician discussed concerns about raising your body temperature? ☐ No ☐ Yes
explain:____

8) Do you smoke? ☐ No ☐ Yes

9) Do you follow a restricted diet? ☐ No ☐ Yes, specify:_______________________________________

10) Do you follow a regular exercise program? ☐ No ☐ Yes

11) What is your stress level? High ☐ Medium ☐ Low ☐

List any medications you take regularly:____

List any over the counter medications (including vitamins, herbal supplements, aspirin, etc.) you take

regularly: ____

12) Do you experience any problems sleeping? ☐ No ☐ Yes

How many hours do you typically sleep each night? ________

13) How much water do you drink daily? ____________________

14) Do you wear contact lenses? ☐ No ☐ Yes

15) Have you been exposed to the sun or used a tanning bed in the last 48 hours? ☐ No ☐ Yes

16) How frequently are you exposed to the sun or use a tanning bed? _____ Infrequently _____ Frequently
_____ Regularly

17) Do you have any metal implants or wear a pacemaker? ☐ No ☐ Yes

18) Have you ever experienced claustrophobia? ☐ No ☐ Yes

19) Do you suffer from sinus problems? ☐ No ☐ Yes

20) Have you ever had an allergic reaction to any of the following? (Please circle any that apply and explain)

Cosmetics ☐ Medicine ☐ Food ☐ Animals ☐ Sunscreens ☐ Iodine ☐ Pollen ☐ AHAs

Fragrance ☐ Shellfish ☐ Latex ☐ Drugs Other:_____________

If yes, please explain:____

21) Do you have raised,rough patches (actinic Keratosis) on arms, legs or other areas of your body?____Yes
____ No

a. If so are you interested in learning about treatment for them? ____ Yes ____ No

Female Clients Only:

23) Are you taking oral contraceptives? ☐ No ☐ Yes, specify: ______________________

24) Any recent changes to or from your contraceptive treatment? ☐ No ☐ Yes, If so, what and when? __________

____

____

25) Are you pregnant or trying to become pregnant? ☐ No ☐ Yes

26) Are you lactating? ☐ No ☐ Yes

27) Any menopause problems? ☐ No ☐ Yes, specify:

Facial/Skin Clients:

1) Do you use Retin-A, Renova, Adapalene Hydroxyl Acid, Deferin, Glycolic Acid, AHA, Salicylic Acid or Retinol/vitamin A derivative products? ☐ No ☐ Yes, describe: ______________________

2) Have you used any of these products in the last 3 months? ☐ No ☐ Yes

3) Have you used an acne medication? ☐ No ☐ Yes, when? __________ Which drug? __________

4) Do you form thick or raised scars from cuts or burns? ☐ No ☐ Yes

5) Do you have Hyperpigmentation (darkening of the skin) or Hypopigmentation (lightening of the skin) or marks after physical trauma? ☐ No ☐ Yes, describe: ______________________

6) What has been bothering you most about your skin in the past 30-60 days? ______________________

7) What skin products do you use at home? ______________________

8) On a scale of 1 to 10 (1 being least and 10 being most) how committed are you to your home care regimen?

____

9) Have you had Botox, Dysport (or other) or Filler? ______ yes (circle which ones)
______ no

a. when was the last time ? ______________

b. where did you have it done? ______________ By whom? ______________

Massage Clients:

1. What is your major complaint: ____

____

2. Goals for your massage therapy today___Relaxation____Rehabiliation ____ High activity level maintenance

3. Preferred type of touch:____ light/meditative____heavy/invigorating ____ deep/trigger point

MARK AREAS OF DISCOMFORT

I understand that massage is designed for the purpose of relaxation and relief from tension, muscle spams or poor circulation. The massage therapist cannot diagnose medical issues/disease/disorders or perfome spine palpitations. ______ initial

I understand, have read and completed this questionnaire truthfully. I agree that this constitutes full disclosure, and that it supersedes any previous verbal or written disclosures. I understand that withholding information or providing misinformation may result in contraindications and/or irritation to the skin or body from treatments received. I am aware that it is my responsibility to inform the therapist of my current medical or health conditions and to update this history. The treatments I receive here are voluntary and I release this institution and/or professional from liability and assume full responsibility thereof. I understand the recommendations and suggestions are within the scope of practice of the therapist based on certifications, licenses and education and are not to be considered or to replace medical treatment. In addition, if photos are taken to document treatment progress I give my consent to their use for promotional or advertising and educational purposes without payment or consideration.

Client's Signature: ______________________________ Date: ____________

Therapist's Signature: ______________________________ Date: ____________