Soteria Wellness Confidential Client Health History Form

Name: _____ Assessment Date: _____
Address: _____ Phone (day): _____
_____ Phone (night): _____
Referred By: _____ Birth Date: _____
Occupation: _____ Gender: M_____ F_____
Sports/Hobbies: _____Email: _____
Emergency Contact (name/phone): _____

To ensure a safe and comfortable massage/bodywork experience, please take a moment to carefully answer the following questions.

- Have you received professional massage/bodywork in the past? Yes/No If yes, what type? _____
- Do you have any difficulty lying on your front, back, or side? _____
- Prioritize areas of concern or pain: _____
  _____
- Areas you prefer not to have massaged: _____
- Allergies to lotions, ointments, etc.: _____
- Do you wear: contact lenses( ) glasses( ) past or present orthodontic appliances/braces( ) dentures( ) wig( ) and/or a hearing aid( )?
  _____
- Have you consumed alcohol/recreational drugs in past 24 hours? Yes/No _____
- Are you currently under care of a health care practitioner? If yes, please explain. _____
- Please list and explain all medications (including aspirin, herbal remedies, and supplements) you are currently taking: _____
  _____
  _____
- Please list (with year if known) all surgeries, hospitalizations, falls, accidents, injuries, and major illnesses: _____
  _____
  _____
  _____
- For women: Are you pregnant? Yes/No If yes, how many months? List any complications: _____
- Is there anything else you would like me to know about your general health or treatment goals and preferences? _____
  _____
  _____
  _____
  _____

Health History: Please check/circle and explain any that apply.

Musculo-Skeletal

□ bone/joint disease_____ □ bone fracture_____
□ arthritis_____ □ bursitis/tendonitis_____
□ pins/plates/artificial joint_____ □ jaw pain/TMJ_____
□ osteoporosis_____ □ muscular disease/disorder_____
□ sprain/strain_____ □ low back/hip/leg pain_____
□ neck/shoulder/arm pain_____ □ headaches/head injury_____
□ spasms/cramps_____ □ other_____

Skin

□ allergy to lotions etc._____ □ rash/fungal infection_____
□ athlete's foot/warts_____ □ open sore/wound_____
□ bruise easily_____ □ other_____

Digestive

□ constipation_____ □ diarrhea_____
□ abdominal pain/cramps_____ □ heartburn/reflux_____
□ nausea/vomiting_____ □ other_____

Circulatory/Respiratory

□ heart condition_____ □ asthma_____
□ high/low blood pressure _____ □ sinus problems_____
□ lymphedema_____ □ allergies (specify)_____
□ varicose veins_____ □ difficulty breathing_____
□ blood clots_____ □ other_____

Nervous

□ herpes/shingles/cold sores_____ □ numbness/tingling_____
□ chronic pain_____ □ tired/fatigued_____
□ sleep disorders_____ □ seizure/fainting_____
□ nerve compression_____ □ peripheral neuropathy_____
□ cold/tingling extremities_____ □ confusion/depression_____
□ anxiety/stress_____ □ other_____

Reproductive/Urinary

□ PMS_____ □ kidney/bladder trouble_____
□ pregnant/stage_____ □ STD/other_____

Other

□ diabetes type I/type II_____ □ cancer/tumors_____
□ vision/hearing impaired_____ □ eating disorder_____
□ caffeine/nicotine/alcohol/drug use_____ □ other_____

Please read each statement and sign below.

It is my choice to receive massage, CranioSacral Therapy, or other body work modalities for the wellbeing of my body and mind. I realize that the treatment I receive is for the basic purpose of relaxation, improved circulation, pain relief and other effects supported by research and experience. If I notice any pain or discomfort during this or any future session, I will immediately inform the practitioner so that the pressure and/or strokes may be adjusted to my level of comfort.

I understand that massage/bodywork therapists do not diagnose illness, disease, or any physical or emotional disorder; nor do they prescribe medical treatment, pharmaceuticals, or perform spinal manipulations. I acknowledge that massage is not a substitute for medical care, and that it is recommended that I see a qualified health care provider for the above services.

I have stated all medical conditions that I am aware of and will update the practitioner of any changes in my health status.

_____ _____

Client Signature Date Practitioner Signature Date