Turtle Dance Bodywork
Client Health History Form

Name__________________________________ Date_______________

Address _______________________________ Home Phone________________________________

_______________________________ Work Phone_________________________________

City___________________________________ Email_______________________________________

State__________________________________ Social Security #_____________________________

Zip Code_______________________________

Occupation_____________________________ Male/ Female Date of Birth_________________________________

What specific condition(s) caused you to seek therapy today?____

____

Have you ever had therapeutic massage before? **Yes** **No** **Many Times**

What physical activities do you do on a daily or weekly basis?____

Please circle any painful or tense areas/regions where you tend to hold your stress:

Head/face Low back Shoulders Neck Abdomen Legs/feet Arms/hands

Mid-back Other____

Are you currently under a physicians care? **Yes / No** For what condition?_________________________________

Do you take medication for this condition? **Yes / No**

List any medications you take____

(Prescription or "over the counter" – including aspirin, NSAIDs, etc)

Do you take any medications/drugs that alter sensation (e.g. pain meds, muscle relaxants, alcohol or any depressants or stimulants)? ____

Please circle any of the following health issues that you have had *in the past year*.

Allergies____

Angina	Fibromyalgia	Irritable Bowel Syndrome	Stroke	Asthma	Heart Disease
Insomnia	Surgery	Blood Clots	Hepatitis		Migraines/Headaches
Varicose veins		Cancer	Herpes Simplex		Phlebitis/Thrombosis
Whiplash		Carpal Tunnel Syndrome	Hospitalization		Pregnancy
Communicable Diseases		Hypertension	Repetitive Strain Injuries		Disc Problems
Immune System Conditions		Sciatica	Other___________________________		

Please carefully read the following information, then sign below.

I understand that the massage/ bodywork I receive from Turtle Dance Bodywork is provided for the basic purpose of relaxation and relief of muscular tension. If I experience pain or discomfort during a session, I will immediately inform the practitioner so that the pressure and/or strokes may be adjusted to my level of comfort. I further understand that massage or bodywork should not be construed as a substitute for medical examination, diagnosis or treatment, and that I should see a physician, chiropractor or other qualified medical specialist for any medical or physical condition of which I am aware. I understand that massage/ bodywork practitioners are not qualified to perform spinal or skeletal adjustments, diagnose, prescribe or treat any physical or mental illness, and that nothing said in course of the session should be construed as such. Because massage/ bodywork should not be performed under certain medical conditions, I affirm that I have stated all my known medical conditions and answered all questions honestly. I agree to keep the practitioner updated as to any changes in my medical profile and understand that there shall be no liability on the practitioner's part should I fail to do so. All client information shall be held in strictest confidence except where required by law.

Client Signature____ Date_________________________