HEAL WELL

Naturopathic, Massage and Holistic Services

Name:_____ Birthdate:_____

Email:_____ Phone:_____

Address:_____

Occupation:_____

Medical History (Check all that apply and provide dates)

Muscle/Joint Pain _____
Muscle Stiffness_____
Numbness or Tingling _____
Swelling _____
Bruise Easily _____
Sensitive to touch_____
High/Low Blood Pressure _____
Stroke/Heart Attack _____
Varicose Veins _____
Shortness of breath _____
Cancer _____
Neurological_____
Epilepsy/Seizures_____
Surgeries_____

Headache/Migraines _____
Dizziness/Ringing in Ears _____
Digestive Conditions _____
Gas/Bloating/Constipation_____
Kidney Disease/Infection_____
Arthritis_____
Osteoporosis_____
Scolios _____
Broken Bones (Plates/Screws)_____
Allergies_____
Diabetes_____
Endocrine/Thyroid_____
Depression/Anxiety_____
Memory Loss/Confusion_____

Massage Information

Have you ever had a professional massage before? Yes/No How recently? _____

What kind of pressure do you prefer? (Circle one) Light Medium Deep

What is your goal for today's session? _____

Consent for treatment: If I experience any pain or discomfort during this 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 should not be construed as a substitute for medical examination, diagnosis, or treatment and that I should see a medical specialist for any mental or physical ailment of which I am aware. I understand that massage therapists are not qualified to perform spinal or skeletal adjustments, diagnosis, prescribe, or treat any physical or mental illness, and that nothing said in the course of the session given should be construed as such. Because massage/bodywork should not be performed under certain medical conditions, I affirm that I have stated all known medical conditions and answered all the 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 practitioners part should I fail to do so. I also understand that any illicit or sexually suggestive remarks or advances made by me will result in immediate termination of session and I will be liable for full payment of the entire scheduled appointment. Understanding all of this I give my consent to receive care.

Signature:_____ **Date:**_____