Confidential Health History Form

Name: _____ Date of Birth: _____
Address: _____
Phone Number: _____ (cell/home/work) E-mail: _____
Emergency Contact Name: _____ Emergency Contact Phone: _____
What is your occupation if you are employed? _____
Are you on any medications?☐**YES** ☐**NO** Please list: _____
_____
Are you pregnant?☐**YES** ☐**NO** If yes, what week are you in your pregnancy? _____ Expected Due Date: _____
Have you had a massage before? ☐**YES** ☐**NO** If yes, when was your last massage? _____
What type of pressure do you prefer? (Light/Medium/Firm) _____
What are your goals for your massage? _____
_____
Do you suffer from any physical discomfort?☐**YES** ☐**NO** If Yes, where? _____
_____
Have you had any recent injuries? ☐**YES** ☐**NO**If yes, what is the injury and when did it occur? _____
_____
Are you being treated by a physician now, or have been treated recently? ☐**YES** ☐**NO** If yes, why? _____
_____
Have you undergone any surgical procedures recently? ☐**YES**☐**NO** If yes, please give date and reason: _____
_____
Is there anything else that you feel we should be made aware prior to your treatment? ☐**YES** ☐**NO**
If yes, please explain: _____

Please mark **"C" for current** condition or **"P" for past** condition:

Condition	**C/P**	**Condition**	**C/P**	**Condition**	**C/P**	**Condition**	**C/P**
Allergies		Cancer		Headaches/Migraines		Seizure Disorder	
Arthritis/joint pain		Cardiovascular disease		Muscle tension/pain		Stroke	
Back pain/trauma		Circulation problems		Neck pain/trauma		Swelling	
Blood pressure (high/low)		Diabetes		Neurological Conditions (Parkinson's/MS)		Thrombosis	
Bruise Easily		Digestive issues/constipation		Neuropathy/numbness		Varicose Veins	
Bursitis		Fibromyalgia		Sciatica		Other	

I understand that the services offered are not a substitute for medical care and that any information provided by the therapist is for educational purposes only and is not diagnostically prescriptive in nature. I agree to actively participate, as much as possible, in my own healing. I comprehend that all information provided is confidential.

Client Signature_____ Date of Visit: _____

FOR MINORS RECEIVING A SERVICE (release for those under 18 years of age):
I, _____, here by give my permission for, _____ to have services at SoLu Wellness. I understand that I am required by SoLu Wellness to be in the room with my child and hereby agree to the requirement.

Parent/Guardian Signature: _____ Date of Visit: _____