Trinity Massage Haven
health • wellness • massage

Confidential Client Information & Health History

If you have a cold/flu today we cannot continue. I will be happy to reschedule

A completed form is required by the, State of Pennsylvania and professional health care providers.

First Name: Last Name: Home Phone:

Address: Cell Phone:

City: State: Zip: Birthday:

Occupation: Email (for appointment confirmation and newsletters):

In Case of Emergency (ICE): Phone:

Who do I thank for this referral? _____Family/Friend. Other _____

Are you currently under the care of a physician, chiropractor, or physical therapist for an ongoing condition or problem?

Yes **No** Please describe:

Is your condition related to an accident or injury? **Yes** **No** Please describe:

Have you had any major surgical procedure? **Yes** **No** Please describe:

Are you taking any medications presently? **Yes** **No** Please describe:

Are you currently experiencing any of the following condition? **Yes** **No**

Flu/Cold Inflammation Fever Infection Contagious Disease

Please check any of the following conditions below that currently affect you or that you have experienced in the last 5 years.

Musculoskeletal	**Circulatory**	**Nervous System**	**Other (Continued)**
Fibromyalgia	Hypertension	ALS	Migraines
Spasms/Cramps	Low Blood Pressure	Multiple Sclerosis	Depression
Sprains/Strains Postural	High Cholesterol	Parkinson's Disease	Post Traumatic Stress Disorder
Deviations Decreased Range	Heart Condition	Bell's Palsy	Anxiety/Panic Attacks
of Motion Tendonitis	Blood Clots/Phlebitis	Neuritis	Suicidal Thoughts
Bursitis	Diabetes	Spinal Cord Injury	Seasonal Affective Disorder
Osteoporosis	Anemia	Stroke	Grief Process
Gout	Hemophilia	Trigeminal Neuralgia Seizure	Substance Abuse
Osteoarthritis/Rheumatoid Arthritis	Varicose Veins	Disorders	Physical/Emotional Abuse
TMJ Dysfunction	Reynaud's Disease	Numbness/Tingling/Twitching	PMS
Torticollis	Other	Other	Environmental Sensitivities
Whiplash Syndrome	**Respiratory**	**Digestive**	Allergies
Shoulder Pain	Sinusitis	Indigestion	Postoperative Situation
Frozen Shoulder Syndrome	Dizziness	Gastro esophageal Reflux Disease	Pregnancy
Thoracic Outlet Syndrome	Asthma	Ulcers	Chronic Fatigue
Arm Pain	Trouble Breathing	Gas/Bloating	Cancer
Radial Nerve Compression	Pneumonia	Food intolerances	HIV/AIDS
Carpal Tunnel Syndrome	Other	Gallstones	Lupus
Mid Back Pain	**Skin**	Hepatitis	Thyroid Disorders
Low Back Pain	Open Wound or Sore	Ulcerative Colitis	Kidney Disease
Hip Pain	Rashes Acne	Crohn's Disease	Liver Disease
Sciatica	Warts/Moles	Diverticular Disease	Bladder Infection
Knee Pain	Athletes Foot	Irritable Bowel Syndrome	Pelvic Inflammatory Disease
Ankle Pain	Fungal Infections	Other	Fibroids/Ovarian Cysts
Foot Pain	Dermatitis/Eczema	Insomnia	Endometriosis
Plantar Fasciitis	Psoriasis	Sleep Apnea	Other
Other	Other	Headaches	
		Cluster Headaches	

Do you have Allergies (seasonal, food, products, animals)? YES or NO.

Explain: _____

Is this your first professional massage? **Yes** **No** How often do you get a massage?

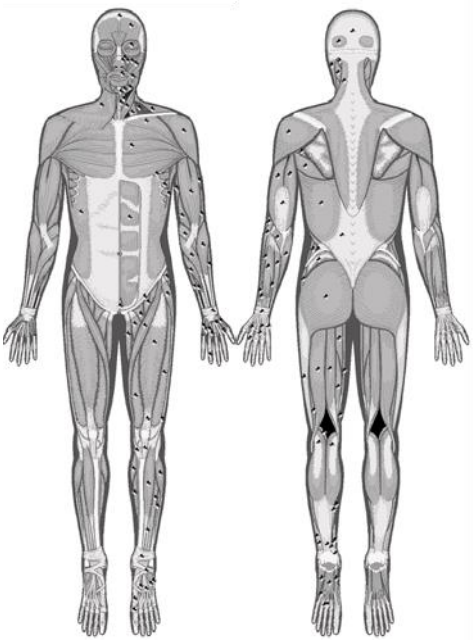
Please circle the number which best describes your current level of stress: (Low) 1 2 3 4 5 (High)

Please circle the number which best describes your current level of health: (OK) 1 2 3 4 5 (Great)

What types of exercise do you engage in regularly?

What do you hope to accomplish from massage?

What is your current pain level of pain? (low) 1 2 3 4 5 6 7 8 9 10 (high)



If you are having problems in a specific body area, please mark them on the diagram below with an "**X**" on the areas:

Pain	**Conditions**
Dull or Achy Sharp or Shooting Burning or Tingling Pins and Needles Numbness Sudden Weakness	Bruising Swelling Rash Spasm Stiffness Decreased Range of Motion

Therapist Notes:

Consent for Care:

I understand that the therapist, at **Trinity Massage Haven** do not practice medicine or chiropractic health care services. I understand that there are contraindications to massage and I affirm that I have stated all my known medical conditions, and answered all questions honestly. I agree to keep Trinity Massage Haven updated on any changes in my medical condition. Payment is due upon completion of the therapeutic service. Please make checks payable to **Trinity Massage Haven.** Returned checks will be assessed a $30.00 charge. If you are unable to keep an appointment, please give 24 hours notice prior to the appointment. Appointments, which have not been canceled within the specified timeframe (per online scheduling settings) $30 will be billed directly to the client. Client services and chart information are confidential. Written authorization is required from you to release information. **If you are sick (cold/flu) you cannot receive a massage today. I will be happy to reschedule your appointment.**

I have read the above statements, agree to the terms, and declare the provided health information is accurate. I have had an opportunity to read the Client Bill of Rights, issued by the Pennsylvania Office of Complementary and Alternative Medicine, know I can request a copy for my own records, and understand my rights in full.

Signature: Date: