

# Client Health History

Please print clearly and complete both sides of this form. This information is critical to your treatment as it will allow the therapist to structure your session. All information disclosed is kept in strict confidence.

~Donna Menezes-Enos LCMT

*Print clearly and complete both sides of this form. This information is critical to your treatment in the Therapy Center as it may affect the manner in which your therapist structures your session. All information disclosed is kept strictly confidential.*

Name \_\_\_\_\_ Date \_\_\_\_\_

Address \_\_\_\_\_  
Street City State Zip

Home phone \_\_\_\_\_ Work phone \_\_\_\_\_

Male / Female \_\_\_\_\_ Date of birth \_\_\_\_\_ Occupation \_\_\_\_\_

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

What is the amount of tension in your life? 0.....1.....2.....3.....4.....5.....6.....7.....8.....9.....10  
none average extreme

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

Please circle any painful or tense areas as well as regions that you tend to hold your stress:

Head/face                      Low back                      Shoulders                      Neck                      Abdomen  
 Legs/feet                      Arms/hands                      Mid-back                      Other (please describe) \_\_\_\_\_

Are you currently under a physician's care? **Yes / No** For what condition? \_\_\_\_\_

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

List medications you do take \_\_\_\_\_

Do you take any medications or drugs that alter sensation (e.g., pain medication, muscle relaxants, alcohol or other depressants or stimulants)? These may affect the Student's/Therapist's choice of techniques.

**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 clot	Hepatitis	Migraines/Headaches	Varicose veins
Cancer	Herpes simplex	Phlebitis/Thrombosis	Whiplash
Carpal Tunnel Syndrome	Hospitalization	Pregnancy	Other: _____
Communicable diseases	Hypertension	Repetitive Strain Injuries	_____
Disk problems	Immune system conditions	Sciatica	_____

*Note: Clients with complex health issues are not always suitable for massage in a student setting and may be referred to a professional setting. In particular, individuals who are pregnant or who are currently in cancer treatment will be referred to our professional therapy center for massage therapy.*

**Client: Please continue on the other side.**

\_\_\_\_\_  
 For therapist use. List client preferences, supports, positioning, table height, etc.

**General Medical Signs and Symptoms.** Please indicate if you *currently* have any of the following conditions.

Symptom		Yes	No	Location: Please describe
1	Any areas of infection?			
2	Any areas of swelling, edema or tendency to swell?			
3	Any areas of numbness or Altered sensation?			
4	Any areas of pain or tenderness?			

**Specific Medical Conditions.** Therapeutic massage may affect these and your health. For your safety, our therapists must be aware of *all medical conditions*.

Condition		Yes	No	Please Describe
5	Arthritis			
6	Cancer or Tumors			
7	Cardiovascular Diseases			<i>Please circle all that apply:</i> anemia, angina, arteriosclerosis, congestive heart failure, heart attack, heart murmur, hemophilia, hypertension, varicose or spider veins, other (please describe):
8	Diabetes			
9	Injuries			
10	Kidney, Liver or Urinary problems			
11	Respiratory Conditions			
12	Skin Conditions			<i>Please circle all that apply:</i> acne, abrasions/cuts, birthmarks/moles, bruises, dermatitis, eczema, herpes, hives, poison ivy/oak/sumac, psoriasis, skin tags, sunburns, warts, other (please describe):
13	Surgery			Date of Surgery: Describe:
14	Gastrointestinal Problems			
Other Medical Conditions not mentioned above				

**Please read and sign:**

*I verify that all information provided is correct and current to the best of my knowledge. I understand that any information provided by the student/therapist is for educational purposes only and is not prescriptive or diagnostic in nature. I hereby give my consent to receive therapeutic massage in the Therapy Center and will not hold the Muscular Therapy Institute, the Therapy Center or my student/therapist responsible for any personal injury or loss of property.*

Signature \_\_\_\_\_

Date \_\_\_\_\_

**Donna Menezes-Enos LCMT  
Acupuncture Plus Medical Center  
11079 Spring Hill Drive  
Spring Hill Florida 34606**

**Practitioner policy:**

**What you can expect from me**

- I am available to my clients between 9AM and 6PM on Monday thru Friday & Saturday between 9AM and 1PM
- I return calls within 24 hours unless I am out of town.
- Clients are treated with respect and dignity
- Payment is due at the time of service. I accept Cash, Checks, Visa, Mastercard, Discover and Debit cards
- I do not provide direct billing
- I perform services for which I am qualified and will refer to other practitioners when work is not within the scope of practice or not in the client's best interest.
- I customize my treatment to meet my client's needs.
- Privacy and confidentiality are maintained at all times.
- Personal and Professional boundaries are respected at all times.
- All massages are safe and are for the sole purpose of relaxation and or recovery from pain & injury.
- All clients are draped appropriately to ensure respect and dignity.

**Client Policy:**

**What I require from my clients:**

- Clients provide a health history and update as necessary.
- Sessions begin and end at scheduled times. Sessions begun late due to the client arriving late end at the appointed time and are full price.
- If cancellation is necessary, please give 24 hours notice or you can be charged for the appointment. -Emergency cancellations are determined at the practitioner's discretion.
- Payment is expected at the time of Service.
- To be present and not under the influence of alcohol or drugs.
- That you be clean for sessions
- Sexual harassment is not tolerated. If the practitioner's safety feels compromised, the session is stopped immediately.

Client Signature \_\_\_\_\_ Date \_\_\_\_\_

Therapist  
Signature \_\_\_\_\_ Date \_\_\_\_\_