KATHIE TUPPER, LMP

License # MA60289437

"Healing body and mind, one massage at a time"

Confidential Massage Health History Form

Welcome! I would like to make your appointment as pleasant and comfortable as possible. If you have any questions regarding your session, please let me know. Please print legibly.

Name _____ Date of Birth _____
Address _____ City _____ State _____ Zip _____
Contact Phone _____Emergency Contact_____
Height _____ Weight_____ Occupation _____
Email Address_____ (will not be sold or shared)

☐ **Yes! Add me to your email list for up coming specials and coupons for birthdays, holidays and more.**

Referred by (I will thank them) or how did you hear about me? _____
Have you ever received Massage Therapy? _____ Yes _____ No
If Yes, How often? _____
Type of Massage experienced (Swedish, Deep Tissue, Rolfing, Orthopedic, Trigger Point)
_____
Are you currently taking any medications? _____ No _____ Yes
If yes please list _____
Primary Physician _____ Contact Phone _____
Chiropractor _____ Contact Phone _____
I give my massage therapist permission to consult my health care providers regarding my health and treatment _____ Yes _____No
List any surgeries you have had: _____
Describe any accidents, injuries, you have had. What year did these happened?
_____
Do you have the following? ____ Skin rash ____ cold/flu ____ open cuts ____ severe pain ____ Anything contagious ____ injuries/bruises
List any allergies: _____
Do you have any allergies to oils, lotions, ointments, essential oils, nuts? ____ No ____Yes
If yes, explain: _____
Are you wearing: ____Contact lenses ____ Hearing Aid ____ Hairpiece ____ Prosthesis ____ Dentures
What are your goals/expectations for this massage therapy session? (Circle all that apply)
Relaxation/stress relief; Pain management; Injury recovery; Injury prevention;
Other please explain: _____

Monahan Healing Arts Building, 1209 11th Street, Suite #2, Bellingham, WA 98225
360-220-7213 ----- ***onemassageatatime@gmail.com***

Please review this list and check those conditions that have affected your health either recently or in the past. Put a P for Past or a C for current.

General

____ Headaches ____ Pain ____ Sleep disturbances ____ Fatigue ____ Infections
____ Fever ____ Sinus ____ Other, please explain _____

Skin Conditions

____ rashes ____ athlete's foot, warts ____ Other, please explain _____

Muscles/Joints

____ rheumatoid arthritis ____ Osteoarthritis ____ Osteoporosis ____ Scoliosis
____ broken bones ____ Spinal problems ____ disk problems ____ lupus
____ TMJ/jaw pain ____ Spasms/cramps ____ tendinitis, bursitis
____ Stiff or painful joints____ weak/sore muscles ____neck, shoulder, arm pain
____ low back, hip, leg pain ____ Other, please explain _____

Nervous System

____ Head injuries/concussions ____ Dizziness/ringing in ears ____ numbness/tingling
____ loss of memory, confusion ____ Sciatica, shooting pain ____ chronic pain
____ Depression ____ Other, please explain _____

Respiratory, Cardiovascular

____ heart disease ____blood clots ____ stroke ____ lymphedema ____poor circulation
____ high/low blood pressure ____ irregular heart beat ____ swollen ankles ____varicose veins
____ Chest pain, shortness of breath ____ asthma

Digestive

____ bowel problems ____ gas, bloating ____ bladder/kidney/prostate
____ abdominal pain ____ Other, please explain _____

Endocrine System

____ Thyroid ____ Diabetes

Reproductive System

____ Pregnancy ____ painful, emotional menses ____ fibrotic cysts

Cancer/Tumors

____ benign ____ malignant

Habits

____ tobacco ____ alcohol ____ drugs ____ coffee, soda

Please read the following and initial each statement and sign below:

____ I understand that although massage can be very therapeutic, relaxing, and reduce muscular tension, it is not a substitute for medical examination, diagnosis, and treatment.

____ This is a therapeutic massage any sexual remarks or advances will terminate the session and I will be liable for payment of scheduled treatment.

____ Being that massage should not be performed under certain medical conditions, I affirm I have answered all questions pertaining to medical conditions truthfully and will inform my practitioner of any changes in my health.

____ I have been given a copy of office policy and will abide by the cancellation policies as well as the in house policies.

Signature: _____Date_____

Therapist: _____ Date _____

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