

# HEALTH HISTORY FORM

**PERSONAL INFORMATION:**

Today's Date: \_\_\_\_\_

Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Phone (Home/Cell): \_\_\_\_\_ Email: \_\_\_\_\_

How did you hear about us? (List name of person if referral.): \_\_\_\_\_

Would you like more information from Wave Wellness about the following?

- **Infrared Sauna:**    \_\_\_ Yes \_\_\_ No
- **Cold Plunge Therapy:**    \_\_\_ Yes \_\_\_ No

**EMERGENCY CONTACT:**

Name / Relationship: \_\_\_\_\_ Phone: \_\_\_\_\_

**CIRCLE ALL THAT APPLY:**

AIDS/HIV	Contagious Skin Condition	Hepatitis	Open Sores/Wounds	Pregnancy ___ months
Arthritis/Rheumatism	Diabetes	Herniated Disc	Osteoporosis	
Broken Bone	Easy Bruising	Hypertension	Pinched Nerve	Other: _____
Bursitis	Epilepsy	Hypotension	Scoliosis	
Cancer	Fibromyalgia	IBS	Thyroid Problems	Current Medications:
Carpal Tunnel	Heart Disease	Migraine Headaches	TMJ	_____

**HEALTH CONCERNS**

List any other health concerns: \_\_\_\_\_

Are you allergic to any oils or lotions? \_\_\_\_\_ If yes, explain: \_\_\_\_\_

Have you ever had a professional massage? \_\_\_\_\_

What results do you want from your massage? \_\_\_\_\_

It is my choice to receive Massage Therapy. I realize that the treatment is being given for the well being of my body and mind. This includes stress reduction, relief from muscular tension, spasm or pain, or for increasing circulation or energy flow. I agree to communicate with my practitioner any time I feel like my well being is being compromised. I understand that massage practitioners DO NOT diagnose illness, disease, or any physical or mental disorder; nor do they prescribe medical treatment, pharmaceuticals or perform spinal thrust manipulations. I acknowledge that Massage is not a substitute for medical examination or diagnosis and that it is recommended that I see a primary health care provider for that service.

I have stated all medical conditions/medications and treatments that I am aware of and will update the massage practitioner of any changes.

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