wave
WELLNESS

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	Hepatisis	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 _____

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