BodyRealms **HEALTH HISTORY** Date:

Name:		Date of Birth:	
Nickname/Preferred Alias:		Gender: M/F/Other:	
Address:	City:	State:	Zip:
Phone: (H) (W) (C)			
Emergency Contact: (Name) (Phone Number)			
Occupation:			
Name of Parent/Gaurdian (if patient is a minor):			
Primary Health Care Provider: Phone: Address: City: State: Zip:			
I authorize my massage therapist to consult with my health care provider (if needed) in regards to my health and treatment. Comments: Signature: Date: Initials of Parent/Gaurdian and Date:			
How would you rate your general state of health? Excellent/Good/Fair/Poor			
Health Concerns: (please be as descriptive as possible)			
Are you seeing a health care provider for any of these conditions? Y/N If yes, whom are you seeing and for which conditions?			
Do any of these conditions limit your daily activities? Y/N If so, in what ways?			
Have you received massage therapy before? Y/N When was your last session? Did you enjoy the treatment? (please describe what you liked as well as what could have been improved)			
Current Medications: (including any over the counter pain relievers)			
Current Supplements:			
Do you? Smoke Tobacco (___packs/day) Drink (____drinks/day) Use recreational drugs (please comment further _____)			
Allergies:			

Accidents/Injuries: Y/N Dates and Descriptions:

Surgerical Operations: Y/N Dates and Descriptions:

Other Hospitalizations: Y/N Dates and Descriptions:

Do you currently have or have you had? (circle all that apply)

Rashes/Open Sores/Blisters/Warts/Psoriasis/Headaches/Sinus Problems/Arhtritis/Scoliosis/Broken Bones/TMJ Dysfunction or Jaw Pain/Sprains or Strains/Muscle Spasms/Tendonitis or Bursitis/Numbness or Tingling/Sciatica or Shooting Pain/Depression/Anxiety/Heart Disease/Blood Clots/Stroke/High Blood Pressure/Low Blood Pressure/Varicose Veins/Asthma/Chest Pain/Bowel Dysfunction/Gas or Bloating/Diabetes/Hyperthyroidism/Hypothyroidism/Immunological Condition (please elaborate_____) Other:

Consent and Contract for Care: I promise that I have been truthful and provided the correct information, to the best of my knowledge, of my health conditions. If at anytime my condition changes I will notify my therapist. I also promise to actively participate in my treatment in order to obtain the highest results for my own health. If at anytime I feel my health and well-being is overlooked and not top priority, I will inform my therapist. I have chosen and give my consent to receive massage therapy and other body work treatments.

Signature: Date:

Signature of parent/gaurdian if client is a minor: Date:

Cancellation Policy and Credit Card on File Agreement and Authorization: We respectfully require at least 24 hours notice of cancellations and schedule changes. By signing below I authorize BodyRealms to charge my credit card on file for late cancellations or schedule changes in the full amount of the scheduled session. In consideration of BodyRealms, its practitioners, and the integrity of my wellness plans I agree to and authorize BodyRealms to keep my credit card on file. I understand that it is my responsibility to keep my account up to date. I recognize that I will be responsible for payment immediately, and I authorize BodyRealms to charge my credit card on file for any unpaid sessions.

Credit Card Number:

_____

Three digit code from back of card:

_____

Credit Card Type: Visa/Mastercard Expiration Date:

Client Signature: Date: