McAnsh LIFE-ENERGY Institute

Reducing Stress for Greater Success...in ALL Areas of Life

RELAXING Massage THERAPY

Client Health History Form

Your confidential health history is being requested for your health and safety. Massage affects a variety of body systems. Your response on the following questions helps us create a session plan specifically tailored for you and your needs.

Name: _____ Date: _____

Address: _____ City / State / Zip: _____

Telephone (preferred): _____ Telephone (alternate): _____

Occupation: _____ Email: _____

Date of Birth: _____ Height / Weight: _____

Are you currently under the care of a physician? ☐ No ☐ Yes If yes, please indicate condition: _____

Are you currently taking any medications? ☐ No ☐ Yes If yes, please indicate medication(s): _____

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

Do you wear contact lenses? ☐ No ☐ Yes Do you wear dentures or other dental appliances? ☐ No ☐ Yes

On a scale of 0 (no tension) to 10 (high levels of stress), please indicate the amount of tension in your life:

0 ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10 ☐

Have you had any accidents? ☐ No ☐ Yes If yes, please provide details: _____

Do you consider yourself fully recovered? ☐ No ☐ Yes If no, please explain: _____

Have you been hospitalized in the last two years? ☐ No ☐ Yes If yes, please explain: _____

Are there any areas of your body you do **not** want addressed during your session? _____

How did you hear about us? _____

Would you be open to learning about other NATURAL wellness care products and services we offer? ☐ No ☐ Yes

Do you prefer your Massage therapist to talk during your massage session? ☐ No ☐ Yes

In case of emergency, please contact: _____

Please complete Reverse Side➔

General Medical Information: For your safety, your massage therapist must be aware of any history of the following medical conditions. Therapeutic massage may affect these conditions and your health. Please indicate in the table below if you have ever experienced any of the following conditions.

Medical Condition	Yes	No	Location and Description
Any areas of infection, cuts or open skin?			
Any areas of swelling, edema or tendency to swell?			
Any areas of numbness or altered sensation?			
Any areas of pain or tenderness?			
Arthritis			
Cancer or Tumors			
Cardiovascular Disease			
Diabetes			
Injuries			
Kidney, Liver or Urinary Problems			
Respiratory Conditions			
Skin Conditions			
Previous or Recent Surgeries			
Gastrointestinal Problems			
Pregnancy			

I understand and agree to the following:

1. The massage therapist does **not** work within the parameters of licensed medical professionals; therefore the massage therapist does not diagnose nor prescribe for diseases. Within the scope of teaching and facilitating, the massage therapist **may** recommend self help exercises, nutritional advice, and/or suggest water intake. The client may or may not choose to do any of the suggestions.
2. It is the responsibility of the client to keep the massage therapist informed of ALL medical treatments and/or conditions. Written permission from the physician, chiropractor, physical massage therapist, etc. to the massage therapist that massage may be continued **may** be required in the instances of contraindications.
3. If the client wishes to end their session, they may do so at any time.
4. All clients will be notified of changes in fees (when needed) BEFORE their session begins.
5. Payment is required immediately before or after services are rendered and **the client will be charged a $25.00 missed appointment** fee for any missed appointments without more than **4 hours advanced notice**. If running behind you will be charged the full amount of the scheduled massage while only receiving massage during your remaining time left.
6. Sexual advances of any kind will not be tolerated and the session will end immediately. The fee for the session will **not** be refunded.
7. I have read and understand this information. Any questions that I had have been answered to my satisfaction be the massage therapist. All medical conditions I am aware of have been disclosed and/or discussed with the massage therapist.
8. I understand that some insurance companies will cover massage therapy when referred by a doctor. I understand that ML-EI will follow the correct procedures in billing these services but there is **no** guarantee that the services will be paid by my insurance company. If no payment is received, I agree to pay for all services in full.

Signature: _____ Date: _____

*Signature: _____ Relationship: _____

* Parent or legal guardian if client is under the age of 18.