

SYNERGY HEALING ARTS CENTER & MASSAGE SCHOOL HEALTH INFORMATION

Message Client _____

Date _____

A. Client Information

Address _____
City/State/Zip _____
Phone: Home (____) _____ - _____
Work (____) _____ - _____ Cell (____) _____ - _____

Date of Birth _____

Height _____

Employer _____
Work Address _____
Occupation _____
Emergency Contact _____
Phone: Home (____) _____ - _____
Work (____) _____ - _____ Cell (____) _____ - _____

Weight – please check

Under 250 lbs

Over 250 lbs

Have you received massage therapy before?
Frequency? _____

Primary Health Care Provider _____
Address _____
City/State/Zip _____
Phone: _____ Fax: _____

What are your goals for receiving massage therapy?

I give my massage therapist permission to consult with my health care providers regarding my health and treatment.
Comments _____
Initials _____ Date: _____

B. Current Health Information

List Health Concerns. Check all that apply

Primary N/A _____

- mild moderate disabling
 - constant intermittent
 - symptoms ↑ w/activity ↓ w/activity
 - getting worse getting better no change
- treatment received _____

Secondary N/A _____

- mild moderate disabling
 - constant intermittent
 - symptoms ↑ w/activity ↓ w/activity
 - getting worse getting better no change
- treatment received _____

Additional N/A _____

- mild moderate disabling
 - constant intermittent
 - symptoms ↑ w/activity ↓ w/activity
 - getting worse getting better no change
- treatment received _____

C. Health History

List and explain. Include dates and treatment received.

Surgeries N/A _____

Injuries N/A _____

Major illnesses N/A _____

List Current Medication & Herbal Remedies
Medication Condition used for

PLEASE COMPLETE THE OTHER SIDE

**PLEASE CHECK ALL CURRENT AND PREVIOUS CONDITIONS
& LIST SPECIFIC MEDICATIONS**

GENERAL			NERVOUS SYSTEM			ALLERGIES		
Current	Past	Medication	Current	Past	Medication	Current	Past	Medication
<input type="checkbox"/>	<input type="checkbox"/>	headaches_____	<input type="checkbox"/>	<input type="checkbox"/>	head injuries_____	<input type="checkbox"/>	<input type="checkbox"/>	scents, oils_____
<input type="checkbox"/>	<input type="checkbox"/>	pain_____	<input type="checkbox"/>	<input type="checkbox"/>	Concussions_____	<input type="checkbox"/>	<input type="checkbox"/>	lotions_____
<input type="checkbox"/>	<input type="checkbox"/>	sleep disorders_____	<input type="checkbox"/>	<input type="checkbox"/>	loss memory/confusion_____	<input type="checkbox"/>	<input type="checkbox"/>	detergents_____
<input type="checkbox"/>	<input type="checkbox"/>	fatigue_____	<input type="checkbox"/>	<input type="checkbox"/>	dizziness_____	<input type="checkbox"/>	<input type="checkbox"/>	other_____
<input type="checkbox"/>	<input type="checkbox"/>	infections_____	<input type="checkbox"/>	<input type="checkbox"/>	ringing in ears_____	DIGESTIVE/ELIMINATION SYSTEM		
<input type="checkbox"/>	<input type="checkbox"/>	fever_____	<input type="checkbox"/>	<input type="checkbox"/>	sciatica shooting pain_____	<input type="checkbox"/>	<input type="checkbox"/>	bowel problems_____
<input type="checkbox"/>	<input type="checkbox"/>	sinus_____	<input type="checkbox"/>	<input type="checkbox"/>	chronic pain_____	<input type="checkbox"/>	<input type="checkbox"/>	gas, bloating_____
<input type="checkbox"/>	<input type="checkbox"/>	other_____	<input type="checkbox"/>	<input type="checkbox"/>	depression_____	<input type="checkbox"/>	<input type="checkbox"/>	bladder/kidney/prostrate_____
MUSCLES AND JOINTS			RESPIRATORY, CARDIOVASCULAR			<input type="checkbox"/>	<input type="checkbox"/>	abdominal pain_____
<input type="checkbox"/>	<input type="checkbox"/>	rheumatoid arthritis_____	<input type="checkbox"/>	<input type="checkbox"/>	heart disease_____	<input type="checkbox"/>	<input type="checkbox"/>	other_____
<input type="checkbox"/>	<input type="checkbox"/>	osteoarthritis_____	<input type="checkbox"/>	<input type="checkbox"/>	blood clots_____	ENDOCRINE SYSTEM		
<input type="checkbox"/>	<input type="checkbox"/>	osteoporosis_____	<input type="checkbox"/>	<input type="checkbox"/>	stroke_____	<input type="checkbox"/>	<input type="checkbox"/>	thyroid_____
<input type="checkbox"/>	<input type="checkbox"/>	scoliosis_____	<input type="checkbox"/>	<input type="checkbox"/>	lymphadema_____	<input type="checkbox"/>	<input type="checkbox"/>	diabetes_____
<input type="checkbox"/>	<input type="checkbox"/>	broken bones_____	<input type="checkbox"/>	<input type="checkbox"/>	high/low blood pressure_____	<input type="checkbox"/>	<input type="checkbox"/>	other_____
<input type="checkbox"/>	<input type="checkbox"/>	spinal problems_____	<input type="checkbox"/>	<input type="checkbox"/>	irregular heart beat_____	REPRODUCTIVE SYSTEM		
<input type="checkbox"/>	<input type="checkbox"/>	disk problems_____	<input type="checkbox"/>	<input type="checkbox"/>	poor circulation_____	<input type="checkbox"/>	<input type="checkbox"/>	pregnancy_____
<input type="checkbox"/>	<input type="checkbox"/>	lupus_____	<input type="checkbox"/>	<input type="checkbox"/>	swollen ankles_____	<input type="checkbox"/>	<input type="checkbox"/>	PMS_____
<input type="checkbox"/>	<input type="checkbox"/>	TMJ, jaw pain_____	<input type="checkbox"/>	<input type="checkbox"/>	varicose veins_____	<input type="checkbox"/>	<input type="checkbox"/>	fibrotic cysts_____
<input type="checkbox"/>	<input type="checkbox"/>	spasms, cramps_____	<input type="checkbox"/>	<input type="checkbox"/>	chest pain_____	<input type="checkbox"/>	<input type="checkbox"/>	other_____
<input type="checkbox"/>	<input type="checkbox"/>	sprains, strains_____	<input type="checkbox"/>	<input type="checkbox"/>	shortness of breath_____	CANCER/TUMORS		
<input type="checkbox"/>	<input type="checkbox"/>	tendonitis, bursitis_____	<input type="checkbox"/>	<input type="checkbox"/>	asthma_____	<input type="checkbox"/>	<input type="checkbox"/>	benign_____
<input type="checkbox"/>	<input type="checkbox"/>	stiff/painful joints_____	<input type="checkbox"/>	<input type="checkbox"/>	other_____	<input type="checkbox"/>	<input type="checkbox"/>	malignant_____
<input type="checkbox"/>	<input type="checkbox"/>	weak/sore muscles_____	SKIN CONDITIONS			<input type="checkbox"/>	<input type="checkbox"/>	other_____
<input type="checkbox"/>	<input type="checkbox"/>	neck/shoulder/arm pain_____	<input type="checkbox"/>	<input type="checkbox"/>	rashes_____	HABITS		
<input type="checkbox"/>	<input type="checkbox"/>	low back/hip/leg pain_____	<input type="checkbox"/>	<input type="checkbox"/>	athlete's foot, warts_____	<input type="checkbox"/>	<input type="checkbox"/>	tobacco_____
<input type="checkbox"/>	<input type="checkbox"/>	other_____	<input type="checkbox"/>	<input type="checkbox"/>	other_____	<input type="checkbox"/>	<input type="checkbox"/>	alcohol_____
Contract for Care			SKIN CONDITIONS			<input type="checkbox"/>	<input type="checkbox"/>	drugs_____
Contract for Care			<input type="checkbox"/>	<input type="checkbox"/>	other_____	<input type="checkbox"/>	<input type="checkbox"/>	coffee, soda_____
Contract for Care			<input type="checkbox"/>	<input type="checkbox"/>	other_____	<input type="checkbox"/>	<input type="checkbox"/>	other_____

I promise to participate fully as a member of my health care team. I will make sound choices regarding my treatment plan based on the information provided by my massage therapist and other members of my health care team, and my experience of those suggestions. I agree to Participate in the self-care program we select. I promise to inform my practitioner any time I feel my well-being is threatened or compromised. I expect my massage therapist to provide safe and effective treatment.

Consent for Care

It is my choice to receive massage therapy. I give my consent to receive treatment. I have reported all health conditions that I am aware of and will inform my practitioner of any changes in my health. I have read and understand this form in entirety. I understand that all therapists located at SHACMS, Inc. are independent contractors and not employees of SHACMS, Inc. and I agree to release SHACMS, Inc. of any and all liability for any injuries, claims, or damages arising out of any services which I receive from independent contractors at SHACMS, Inc.

Signature: _____ Date: _____ Email: _____

