Confidential Client Health History Form

Privacy Notice: *In accordance with HIPAA, Maryland law, and standard ethical practices within the field of licensed therapeutic massage, your personal and health history information is kept strictly confidential. Health history information is gathered to determine which massage techniques and strategies would be of best benefit for you, and to determine which (if any) techniques might be contraindicated by prior or existing medical conditions.*

Personal Information

Name: ___________________________________Date of Birth: _________________________

Phone: ____________________________ (Day) ____________________________ (Evening)

Address: ____

Email: ___________________________________ Occupation: __________________________

Emergency Contact Information: ____

Medical History

Are you currently under medical supervision? ___ Yes ___ No (If "yes," please give details):

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____

Do you have any of the following conditions? (Please circle all that apply, and give details below):

1. Allergies (including inhalant or environmental allergies, food allergies, topical or skin-related allergies)
2. Anxiety Disorders or Phobias
3. Autoimmune Disorders (including lupus, rheumatoid arthritis, scleroderma)
4. Breathing Difficulties (including asthma, bronchitis, COPD, emphysema)
5. Cancer
6. Carpal Tunnel Syndrome
7. Chemical Sensitivities
8. Chronic Fatigue Syndrome
9. Chronic Pain
10. Circulatory Disorders (including aneurism, atherosclerosis, clotting issues, easy bruising, edema, hemophilia, phlebitis, stroke, thrombosis, varicose veins)
11. Cold or Flu Virus/Fever
12. Connective Tissue Disorders (including adhesions, deep scars, plantar fasciitis)
13. Decreased Sensation (to cold/heat/pressure, including diabetic or peripheral neuropathy)

14. Depression or Bipolar Disorder
15. Diabetes (Type I or Type II)
16. Dizziness or Lightheadedness
17. Eating Disorders
18. Epilepsy or Seizure Disorders
19. G.I. Tract Disorders (including acid reflux/GERD, Crohn's Disease, colitis, diverticulitis, gallstones, Irritable Bowel Syndrome, liver issues, peptic ulcers)
20. Grief Process (including effects of loss, separation, trauma)
21. Headaches or Migraines (if "yes," do you have specific known triggers?)
22. High or Low Blood Pressure
23. High Cholesterol
24. High Levels of Stress (including emotional, occupational, or situational)
25. Heart Condition (including aortic issues, arrhythmia, congestive heart failure, heart disease, heart murmur, previous heart attack)
26. Infectious Conditions (bacterial, fungal, parasitic, or viral, including herpes, HIV, Lyme Disease, malaria, polio, Post-polio Syndrome, ringworm, shingles, staph, strep, tuberculosis, viral hepatitis)
27. Joint Issues (including bursitis, ganglion cysts, gout, joint replacements, joint sprains, osteoarthritis, sports injuries)
28. Kidney or Bladder Disorders
29. Localized Pain/Redness/Swelling
30. Muscle or Tendon Issues (including fibromyalgia, hernia, muscle cramps, muscle spasms, muscle strain, muscle weakness, repetitive strain injury, shin splints, tendinitis, tendinosis, Thoracic Outlet Syndrome)
31. Neck/Spinal Issues (including degenerative disc disease, disc herniation, fractures, injury, limited range of motion, sciatic pain, scoliosis, spondylitis)
32. Open Sores or Wounds
33. Pelvic Pain or Related Issues (including endometriosis, Pelvic Inflammatory Disease, Polycystic Ovarian Syndrome, uterine fibroids)
34. Post-Traumatic Stress Disorder (PTSD)
35. Pregnancy
36. Recent Surgery
37. Sinus Issues (including congestion, infection, postnasal drip)
38. Skeletal Issues (including bone spurs, fractures, osteoporosis, Paget Disease, scoliosis)
39. Skin Conditions (including cystic acne, dermatitis, eczema, impetigo, lice, mites, psoriasis, rash, scabies, sunburn)
40. Thyroid Disorders (including hypothyroidism, hyperthyroidism, Grave's Disease)
41. TMJ Syndrome
42. Any acute or chronic disease or medical condition not listed above

Details:

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If you have a chronic condition that has periods of symptom flareup and remission (for example, fibromyalgia or rheumatoid arthritis), are you currently experiencing a flareup?
___ (Yes) ___ (No)

If "No," when was your most recent flareup? ____

Do you have or use any of the following? (Please circle all that apply):

1. Artificial Joints or Prosthetics
2. Birth Control Implant
3. Contact Lenses
4. Dentures
5. Hearing Aids
6. Implanted Catheter --- Hickman, Portocath, etc.
7. Intrauterine Device (IUD)
8. Pacemaker

Are you currently taking any of the following medications? (Please circle all that apply):

1. Anticoagulants/Blood Thinners
2. Calcium Channel Blockers
3. Chemotherapeutic Drugs
4. Steroids

Please list all other prescription medications, over-the-counter medications, and herbal supplements that you are currently taking:

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Have you ever had an allergic reaction to any oils, lotions, creams, ointments, or gels, or to nuts or nut-derived products? ___ Yes ___ No

If “yes,” please give details:

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Massage History

Note: In accordance with Maryland law, all therapeutic massage is performed with a secure drape in place, with only the area being worked exposed. A blanket or extra propping can be provided upon request --- your comfort is important!

Is this your first therapeutic massage? ___ (Yes) ___ (No)

If you've had therapeutic massage before, what is your preferred pressure?

___ Light ___ Medium ___ Deep ___ Varies with Location and Issue

When was your last therapeutic massage? ___________________________

A full-body therapeutic massage includes work on the face, abdomen, and gluteal muscles. Would you prefer *not* to have any of these body areas massaged? ______________________
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Are there any other areas of your body you would prefer *not* to have massaged?
____

Body Mechanics and Stress

Do you have any joints, muscles, or general areas in your body that tend to be injured easily (for example, through repetitive stress, sports, yard work, using heavy equipment?)
___ (Yes) ___ (No)

Details:____
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Have you noticed any areas in your body where you seem to chronically carry stress, tension, tightness, or “knots” in your muscles? ___ (Yes) ___ (No)

Details:____
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Do you frequently experience muscular soreness or stiffness upon waking for the day?
___ (Yes) ___ (No)

Details:____
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Do you spend a lot of hours at the computer, driving, working at a desk, or in any other “forward bend” activity (like holding a baby, using a sewing machine, working on projects at a workbench or table)? ___ (Yes) ___ (No)

Details:____
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Do you spend a lot of hours on your feet (stationary or moving)? ___ (Yes) ___ (No)

Details:____
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Do you practice (or have you tried) any activities aimed at increasing flexibility and relieving physical tension, such as Tai Chi, Yoga, or gentle stretching? ___ (Yes) ___ (No)

Details:____
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Have you experienced any modalities or practices aimed at reducing overall stress and inducing relaxation, such as biofeedback, meditation or Reiki? ___ (Yes) ___ (No)

Details:____
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Are you currently under the care of a chiropractor or physical therapist? ___ (Yes) ___ (No)

Details:____
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Do you have any other issues or concerns not previously addressed in this form?

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Information on Massage Therapy and HIPAA (The Health Insurance Portability and Accountability Act of 1996)

HIPAA's Standards for Privacy cover the basic privacy and protection of the client's records, and any discussion of the client's progress with his or her physician or therapist.

In compliance with HIPAA, prior to your first session, you will receive a Notification of Privacy Policies form, and you will be asked to sign an acknowledgment form indicating that you have read and understood those policies.

If I feel it would be appropriate to contact your physician or therapist to discuss your progress, you will receive a separate authorization form to sign, giving me permission to contact them.

Agreement and Informed Consent to Massage Treatment

I, ___________________________________, have reviewed this form in full, and all information I have provided is true and complete to the best of my knowledge. I agree to inform Kathleen M. Murphy, LMT, CMTPT (massage therapist) of any changes or updates to the information I've provided, including any changes in my health status, and I understand that there shall be no liability on the massage therapist's part should I fail to do so. I understand that certain health conditions may preclude, limit, or modify the type of therapeutic massage I am able to receive.

I understand that massage therapy is intended to promote relaxation and the relief of stress and muscular tension, though results are not guaranteed. I also understand that massage therapy should not be construed as an equivalent or a substitute for medical or psychiatric evaluation, diagnosis, or treatment, and that massage therapy is a different and separate modality from chiropractic treatment, osteopathic treatment, and physical therapy. I understand that I should see a qualified physician or mental health care provider for the evaluation, diagnosis, and treatment of any physical or mental ailment I may have, and should see a qualified chiropractor, osteopath, or physical therapist as appropriate for issues they address which are beyond the scope of practice of therapeutic massage, including spinal or skeletal adjustments.

I understand that I will be receiving a massage within the scope of practice and training of the massage therapist. Massage sessions may include Swedish, myofascial, trigger point, or deep tissue massage techniques with the topical application of appropriate massage oils, lotions, creams, or gels, and may include the application of therapeutic hot or cold packs, facilitated stretching, or Reiki (energy work), as agreed upon with the massage therapist and as the massage therapist determines to be appropriate. If I experience any pain or discomfort during the session, I will immediately inform the massage therapist so the pressure or technique may be adjusted to my level of comfort. I further understand that, as a client, I retain the right of refusal of treatment, and may refuse any therapeutic modality offered or terminate the session at my discretion.

I understand that, in accordance with Maryland law, I will be appropriately draped throughout the session; only the areas being worked will be undraped, and genitals and female breast tissue will be appropriately draped at all times. I understand that therapeutic massage is neither sexual nor invasive in nature. Any illicit or sexually suggestive remarks or advances made by me will result in immediate termination of the session, and I will be liable for

payment of the scheduled appointment.

I understand that while many health insurance companies cover or provide reimbursement for therapeutic massage, this massage therapist does not provide health insurance claim submission or billing services, and cannot guarantee health insurance reimbursement for services. It is solely my own responsibility to contact my health insurance provider to request reimbursement, if appropriate.

______________________________________ ____________________

Signature *Date*

Consent to Treatment of Minor or Dependent

By my signature below, I hereby authorize ___________________________________ to administer massage, bodywork, or somatic therapy techniques to my child or dependent, as she deems necessary and appropriate in her capacity as a licensed massage therapist.

______________________________________ ____________________

Signature of Parent or Guardian *Date*

Consent to Intraoral Massage Treatment

By my signature below, I further give consent to the massage therapist to perform intraoral massage therapy for the muscles of the temporomandibular joint and upper and lower jaw. I understand that the massage therapist determines this work to be appropriate for my particular muscular conditions, and it is within her scope of practice and training.

I understand that intraoral massage therapy provided by the massage therapist will be performed with latex-free gloves. The procedure will be fully explained in advance, and I will be coached in appropriate feedback and relaxation techniques before the procedure begins. If I experience any pain or discomfort during the intraoral work, I will immediately inform the massage therapist so the pressure or technique may be adjusted to my level of comfort. I further understand that, as a client, I retain the right of refusal of treatment, and may refuse any therapeutic modality offered or terminate the intraoral work, or the massage session itself, at my discretion.

I understand that intraoral massage therapy should not be construed as dental or orthopedic work, and is not a substitute for either.

______________________________________ ____________________

Signature *Date*