

**Student Clinic Client Health History Form**

**2017**

**Port Townsend School of Massage – 360.379.4066**

1071 Landes Court, Port Townsend, WA 98368

**Thank you for filling out this form. Please complete the information as completely as possible so that you may receive a massage best suited to your health needs.**

**Date:** \_\_\_\_\_

Name \_\_\_\_\_ Birth Date \_\_\_\_\_

Address \_\_\_\_\_ Phone # - Home \_\_\_\_\_

City \_\_\_\_\_ Phone # - Work \_\_\_\_\_

State \_\_\_\_\_ Zip \_\_\_\_\_ Email \_\_\_\_\_

Age \_\_\_\_\_ Height \_\_\_\_\_ Weight \_\_\_\_\_

General Health Condition \_\_\_\_\_ Blood Pressure \_\_\_\_\_

Occupation \_\_\_\_\_ Other Activities \_\_\_\_\_

Please list any operations, serious or chronic illnesses, or traumatic accidents you have had, and the date of occurrence: \_\_\_\_\_  
\_\_\_\_\_

Are you in recovery from any addictions? \_\_\_\_\_

Are you in recovery from abuse? \_\_\_\_\_

Do you take any medications? \_\_\_\_\_ If yes, name types and for which conditions they're used:

\_\_\_\_\_  
\_\_\_\_\_

Are you under the care of a doctor, chiropractor, or other health care provider? \_\_\_\_\_

If so, for what conditions? \_\_\_\_\_

Do we have permission to contact your health care providers? Yes  No

Names of health care providers:

Name \_\_\_\_\_ Telephone # \_\_\_\_\_

Name \_\_\_\_\_ Telephone # \_\_\_\_\_

Do you wear contact lenses? \_\_\_\_\_ Have you experienced massage therapy before? \_\_\_\_\_

Do you have any especially sensitive areas? \_\_\_\_\_

What do you hope to gain from receiving massage? \_\_\_\_\_

In case of emergency notify: Name \_\_\_\_\_ Phone # \_\_\_\_\_

**Please complete other side →**

Please read the following list of health conditions carefully.

Write a 'P' for a Past concern/condition or a 'C' for a Current concern/condition.

- |   |  |  |
|---|--|--|
| <input type="checkbox"/> AIDS/HIV                 | <input type="checkbox"/> Fibromyalgia                    | <input type="checkbox"/> Raynaud's Phenom. |
| <input type="checkbox"/> Allergies (to _____)     | <input type="checkbox"/> Flu or Cold                     | <input type="checkbox"/> Ringworm          |
| <input type="checkbox"/> _____)                   | <input type="checkbox"/> Fungus                          | <input type="checkbox"/> Scoliosis         |
| <input type="checkbox"/> Arthritis                | <input type="checkbox"/> Headaches/Migraines             | <input type="checkbox"/> Skin Conditions   |
| <input type="checkbox"/> Asthma                   | <input type="checkbox"/> Hepatitis - Type _____          | <input type="checkbox"/> Stroke            |
| <input type="checkbox"/> Back Pain                | <input type="checkbox"/> Herpes Virus                    | <input type="checkbox"/> Swollen feet/legs |
| <input type="checkbox"/> Bursitis                 | <input type="checkbox"/> High Blood Pressure             | <input type="checkbox"/> Tendinitis        |
| <input type="checkbox"/> Cancer/Cancer Treatment  | <input type="checkbox"/> Infection                       | <input type="checkbox"/> Thrombosis        |
| <input type="checkbox"/> Chronic Fatigue Syndrome | <input type="checkbox"/> Low Blood Pressure              | <input type="checkbox"/> TMJ               |
| <input type="checkbox"/> Circulation Problems     | <input type="checkbox"/> Lymph Node Removal (from _____) | <input type="checkbox"/> Varicose Veins    |
| <input type="checkbox"/> Colitis                  | <input type="checkbox"/> Multiple Sclerosis              | <input type="checkbox"/> Warts             |
| <input type="checkbox"/> Depression               | <input type="checkbox"/> Muscle Spasms                   | <input type="checkbox"/> Whiplash          |
| <input type="checkbox"/> Diabetes                 | <input type="checkbox"/> Numbness/Tingling               |  |
| <input type="checkbox"/> Digestive Problems       | <input type="checkbox"/> Osteoporosis                    |  |
| <input type="checkbox"/> Disc Problems            | <input type="checkbox"/> Pain                            | <b>Women Only:</b>                         |
| <input type="checkbox"/> Diverticulitis           | <input type="checkbox"/> Phlebitis                       | <input type="checkbox"/> Menstrual Cramps  |
| <input type="checkbox"/> Fever                    | <input type="checkbox"/> Radiation Tx (to _____)         | <input type="checkbox"/> Pregnancy         |

Describe above Current health conditions, and add any others not listed above: \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_

Please read and sign the following:

I agree to give my full and accurate health history. I understand that I am receiving massage at Student Clinic as part of the Port Townsend School of Massage curriculum. I am aware that each student is being supervised by a Licensed Massage Practitioner who will view the massage during the session. I understand that massage services are intended to be a health aid and in no way take the place of a doctor's care. Information exchanged during any Student Clinic massage session is confidential in nature and is intended to be used for instructional purposes only.

If I need to cancel my appointment, I will give 24 hours notice unless an emergency arises. I agree to pay Port Townsend School of Massage the \$30.00 fee if I miss an appointment without at least 24 hours notice. I understand the student is not licensed and cannot receive payment, tips, trade or gifts for the sessions.

\_\_\_\_\_  
Client Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Instructors' Initials/Dates

### Port Townsend School of Massage Notice of Privacy Practices – Acknowledgement

We keep a record of the health care services we provide you. You may ask to see and have a copy of that record. You may also ask to correct that record. We will not disclose your record to unauthorized sources unless you direct us to do so or unless the law authorizes or compels us to do so. You may see your record or get more information about it by contacting us. A detailed copy of our **Notice of Privacy Practices** is available upon request. By my signature below I acknowledge that I have read the above statement.

\_\_\_\_\_  
Client Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Printed Name