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.

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

Women Only:
_____ Menstrual Cramps
_____ 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