Resolution Health Collaborative, Inc.

Client Health History Form

First _____ Middle _____ Last _____

Date of Birth _____ /_____ /_____ Male Female Other Referred by: _____

Address _____

City _____ State _____ Zip _____

Email _____ Mobile ( ) _____-_____

I would like to receive promotions and updates for Resolution via email: ☐ Yes ☐ No

Occupation _____ Health Insurance Carrier _____

Emergency Contact

Name _____ Relationship _____

Mobile ( ) _____-_____ Work ( ) _____-_____

Please take a moment to carefully read the following information and sign where indicated. If you have a specific medical condition or specific symptoms, massage/bodywork may be contraindicated.
A referral from your primary care provider may be required prior to service being provided.

Have you ever experienced a professional massage session? _____ Yes _____ No

What are your goals for this session?

_____

_____

Which area would you like to receive the most focus?

_____

(turn over)

Please mark any of the following questions to indicate a “yes” answer.

___ Do you frequently suffer from stress?

___ Do you have diabetes? Type _____

___ Do you experience frequent headaches?

___ Are you pregnant? Due Date _____

___ Do you suffer from arthritis?

___ Are you wearing contact lenses?

___ Do you have high blood pressure?

___ Are you taking high blood pressure medication?

___ Do you suffer from epilepsy or seizures?

___ Do you suffer from joint swelling?

___ Do you have varicose veins?

___ Do you have any contagious diseases?

___ Do you have osteoporosis?

___ Do you have any allergies? (Nuts, oils?)

___ Do you bruise easily?

___ Any broken bones in the last two years?

___ Any injuries in the last two years?

___ Do you have cardiac or circulatory problems?

___ Do you suffer from back pain?

___ Do you have numbness or stabbing pains?

___ Are you sensitive to touch or pressure in any area?

___ Have you ever had surgery?

___ Are you taking any medications? (Including Ibuprofen)

___ Other medical conditions

Comments:

_____

_____

_____

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AGREEMENT

I understand that the massage I receive is provided for the basic purpose of relaxation and relief of muscular tension. If I experience any pain or discomfort during this session, I will immediately inform the practitioner so that the pressure and/or strokes may be adjusted to my level of comfort. I further understand that massage or bodywork should not be construed as a substitute for medical examination, diagnosis, or treatment and that I should see a physician, chiropractor, or other qualified medical specialist for any mental or physical ailment of which I am aware. I understand that massage practitioners are not qualified to perform spinal or skeletal adjustments, diagnose, prescribe or treat any physical or mental illness, and that nothing said in the course of the session given should be construed as such. Because massage should not be performed under certain medical conditions, I affirm that I have stated all my known medical conditions and answered all questions honestly. I agree to keep the practitioner updated as to any changes in my medical profile and understand that there shall be no liability on the practitioner's part should I fail to do so. I also understand that 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.

Please call us 24 hours before your appointment if you need to cancel or reschedule. Failure to notify us will result in a 50% charge of scheduled services.

Client Signature _____ Date _____

Consent to Treatment of Minor

By my signature below, I hereby authorize _____ to administer massage, bodywork, or somatic therapy techniques to my child or dependent as they deem necessary.

Signature of Parent or Guardian _____ Date _____