Ginny Massage
"Where your *kneads* come first"

Health History Form

CONFIDENTIAL

(Please fill out BOTH SIDES of this form)

Legal Name (First Middle Last): _____

Today's Date: ____/____/_____ **Last Updated:** ____/____/_____

For ALL types of massage please fill out the following:

Preferred Name: _____ **Date of Birth:** _____ **Gender ( ) M ( ) F**
Phone Number (cell): _____ **Street Address:** _____ **Height:** _____
Phone Number (Other): _____ **City/State:** _____ **Weight:** _____
E-mail: _____ **Zip:** _____ **Occupation:** _____

(ICE) In Case of Emergency PLEASE CONTACT:

PRIMARY **Name:** _____ **Relationship:** _____
Phone Number: _____
SECONDARY **Name:** _____ **Relationship:** _____
(optional) **Phone Number:** _____

Are you currently suffering from or have you ever been treated for any of the following:

( ) Allergies	( ) Diabetes	( ) Heart Condition	( ) Numbness or Tingling
( ) Anxiety Attacks	[ ] - insulin dependent?	( ) Herniated Disc	( ) Osteoporosis
( ) Arthritis	( ) Digestive Concerns	( ) High Blood Pressure	( ) Phlebitis/Thrombosis
( ) Autoimmune Disorder	( ) Dizziness	( ) Infectious Condition	( ) Pregnancy
( ) Athlete's Foot	( ) Edema	( ) Insomnia	[ ] - # of weeks
( ) Bruising/Bruise easily	( ) Epilepsy/Seizures	( ) Loss of Range of Motion	( ) Skin Condition/Rash
( ) Cancer	( ) Convulsions	( ) Multiple Sclerosis	( ) Stiff Neck/Shoulders
( ) Chronic Back Pain	( ) Fibromyalgia	( ) Muscle Spasms	( ) TMJ Dysfunction
( ) Depression	( ) Headaches	( ) Muscle Tension	

Please elaborate or let us know if there is something else here that you experience that is not listed:

_____

_____

_____

Do you have any long-term goals for your body that you would like your therapist to keep in mind?

_____

_____

List any surgeries and include any prostheses, pins, bars, implants, etc.: _____

_____

_____

List current medications: _____

_____

List experienced side effects of these medications: _____

_____

Are you currently under the care of a Doctor/Physician for any reason? ( ) Yes ( ) No
If yes, please explain: _____

_____

Do you wear contact lenses? ( ) Yes ( ) No
Please list any allergies: (e.g. Nuts, Latex, etc.) _____

_____

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Have you had any lymph nodes removed? ( ) Yes ( ) No
Location:_____
Reason:_____

Did someone refer you to us? ( ) Yes ( ) No
Name:_____
If not, how did you hear about us? _____

Have you ever experienced professional massage before? ( ) Yes ( ) No
Preferred pressure? ( ) Light ( ) L/M ( ) Medium ( ) M/F ( ) Firm
Please describe any regular physical activity you do and how frequently:

_____

_____

_____

LEGAL NOTICE:
Please read the following statements, and then sign below to indicate that you have read these statements and to insure that you have filled this form out to the best of your ability.

I understand the above information is strictly confidential between the signing client, his/her parent/guardian if he/she is under the age of 18, Ginny Aseltine, LMT, and Ginny Massage. This information is used by the LMT and Ginny Massage both for business purposes and to help determine any indications or contraindications for treatment. I understand that I am receiving a massage voluntarily and of my own free will.

The signing LMT reserves the right to refuse massage treatment to any individual for any reason, including inappropriate behavior, illicit or sexually suggestive remarks, abusive or threatening behavior, medical contraindications, repetitive cancellations or tardiness, ethical reasons, or if the individual is, or appears to be, under the influence of alcohol or illegal drugs. Any actions that could reasonably be seen as sexual in nature, including sexual references, offensive language, or similar acts, will not be tolerated. The signing LMT has the right to end the session immediately and refuse further treatment for any of the above reasons.

The practitioner whose signature/initials appear below is not responsible for the aggravation of conditions that were present, but not disclosed at the time of the massage and which may be affected by the massage. I hereby release those who have made this massage possible, which includes but not limited to: the massage therapist (LMT), his/her friends, family, co-workers, teachers, Ginny Massage, and Webster Property managers/owners, from any liability that may occur as a result of this session.

Client Signature:_____.

Client's Parent/Guardian Signature:_____.

Ginny Aseltine, LMT Signature/Initials:_____.