# CONFIDENTIAL CLIENT INFORMATION AND HEALTH HISTORY

## Angelical Touch Massage Therapy

Angel Rivera, Licensed Massage and Bodywork Therapist, LMBT, NC #7517
The Health Studio, Inc., 6104 Grace Park Drive, Morrisville, NC 27560
Cellular phone: 919-744-8081

Name: _____ Date of Birth:_____

Address:_____City:_____ State: _____ Zip _____

Phone (home):_____ (work) _____ (cellular) _____

e-mail:_____

Occupation:_____Referred by:_____

Is this your first professional massage? ____

What kind of pressure do you prefer? __ Light __ Medium __ Firm

What do you hope to accomplish from today's massage?_____

Are you aware of any tension holding spots in your body? _____If yes, location(s)

_____

The pubic area, the genitals, the gluteal cleft and the breasts (in females), are covered and are not massaged.

Are there any other areas of your body that you DO NOT want massaged? (Scalp) (Face) (Neck) (Shoulders) (Arms) (Hands) (Upper back) (Upper chest) (Mid back) (Abdomen) (Lower back) (Glutes) (Inside of thighs) (Legs) (Feet)

If you are female, breasts may be treated after we discuss your objectives and appropriate techniques and you complete a separate consent form. Would you like information about recovery from surgery, scar improvement or holistic breast massage? __ No __ Yes, which?_____

Describe any surgeries, hospitalizations, accidents or injuries you have had:

Less than 5 years ago:_____

More than 5 years ago:_____

Do you have any chronic, ongoing pain that you deal with on a regular basis?_____

Please explain:_____

Describe what activities cause this pain and/or make it worse:_____

Are you receiving any other type of medical treatment?_____Please explain:_____

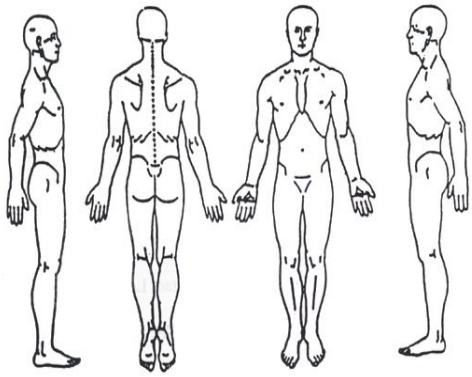
Please list any medication (vitamins, herbs or pharmaceutical) taken now or at regular intervals (include explanation of what medication is used to treat):_____

_____

Are there any other health concerns you wish to discuss today?_____If yes, please describe:_____

_____

On the figure below, please shade in any areas where there is pain or stiffness



If you answer "yes" to any of the following questions, please explain as clearly as possible.

_ Yes _ No Do you frequently suffer from stress?
_ Yes _ No Do you experience frequent headaches?
_ Yes _ No Are you wearing contact lenses?
_ Yes _ No Are you wearing dentures?
_ Yes _ No Do you suffer from joint swelling?
_ Yes _ No Do you have osteoporosis?
_ Yes _ No Do you have high blood pressure?
_ Yes _ No Do you have diabetes?
_ Yes _ No Do you suffer from chronic back pain?
_ Yes _ No Do you suffer from arthritis?
_ Yes _ No Do you bruise easily?
_ Yes _ No Do you suffer from epilepsy or seizures?
_ Yes _ No Do you have varicose veins?
_ Yes _ No Do you have cardiac or circulatory problems?
If yes, are you taking medication? _ Yes _ No
If yes, are you insulin dependent? _ Yes _ No
_ Yes _ No Do you have any allergies? Explain: _____
_ Yes _ No Do you have a diagnostic of cancer? Explain: _____
_ Yes _ No Do you have numbness or stabbing pains? Explain: _____
_ Yes _ No Are you sensitive to touch or pressure in any area? Explain: _____
_ Yes _ No Do you have tension or soreness in a specific area? Explain: _____
_ Yes _ No Other medical condition, or are you taking any medications I should know about?
_____
Women: _ Yes _ No Are you pregnant?

Comments
_____
_____
_____
_____

The above information is accurate and true to the best of my knowledge. I understand that massage therapists do not diagnose disease, prescribe medications or manipulate bones. I further understand that massage therapy is not a substitute for medical attention or examination. I take responsibility for alerting my practitioner to any physical, mental or emotional changes that occur with my health.

Client Signature:_____Date:_____

Practitioner Signature:_____Date:_____

***Consent to Treatment of Minor:*** By my signature below, I hereby authorize Angel Rivera to administer massage, bodywork, or somatic therapy techniques to my child or dependent as they deem necessary.

Signature of Parent or Guardian:_____Date:_____

Name of Parent or Guardian:_____