CORNERSTONE THERAPEUTIC

MARCO MADIAN

Licensed Massage Therapist

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HEALTH HISTORY FORM

All information on this form will be kept strictly confidential.

Name: ______________________________ Date: ______________

Address: ______________________________

Home phone: ______________ Work phone: ______________ Cell phone: ______________

Date of birth: ______________________________ Occupation: ______________

Emergency contact: ______________________________ Phone number: ______________

Relationship: ______________________________

AUTHORIZATION TO TREAT A MINOR

As a parent or legal guardian, I authorize treatment of massage therapy.

Signature: ______________________________ Date: ______________

Are you under the care of a physician? ☐ Yes ☐ No If yes, for what reason? ______________

When did you last have a physical exam?: ☐ Never ☐ 0–6 months ☐ 6–18 months ☐ longer

Have you been hospitalized in the last 5 years for a serious injury, illness or major surgery? ☐ Yes ☐ No

If yes, please explain: ______________________________

Have you ever:	Yes	No	Date	If yes, briefly explain:
had a broken bone?	☐	☐	________	______________________
had sprains or strains?	☐	☐	________	______________________
been struck unconscious?	☐	☐	________	______________________
had a motor vehicle accident?	☐	☐	________	______________________

Do you take minerals, herbs of vitamins? ☐ Yes ☐ No

Please list drugs you now take: ______________________________

____

____

Please indicate of you have any of the following conditions by circling C for CURRENT or P for PAST:

GENERAL
C P Allergies
C P Anemia
C P Cancer
C P Chills
C P Convulsions
C P Diabetes
C P Dizziness
C P Epilepsy
C P Fainitng
C P Fatigue
C P Fever
C P Headache
C P Hepatitis
C P Insomnia
C P Nervous/depressed
C P Neuralgia
C P Numbness
C P Sweats
C P Swelling
C P Tremors

MUSCLE/JOINT
C P Arthritis
C P Bursitis
C P Gout
C P Polio
C P Hernia
C P Low back pain
C P Multiple Sclerosis
C P Neck pain, stiffness
C P Pain btwn. shoulders
C P Sciatica
C P Spinal curvature
C P Swollen joints

CARDIOVASCULAR
C P Angina
C P Arteriosclerosis
C P Deep Vein Thrombosis
C P Chest pain
C P Heart attack
C P Heart disease
C P High blood pressure
C P Low blood pressure
C P Poor circulation
C P Rapid heartbeat
C P Slow heartbeat
C P Stroke
C P Swelling of ankles

GASTROINTESTINAL
C P Colitis
C P Irritable Bowel Syndrome
C P Nausea
C P Stomach pain
C P Ulcers

RESPIRATORY
C P Asthma
C P Heaviness in chest
C P Cough
C P Difficulty breathing
C P Emphysema
C P Pleurisy
C P Pneumonia
C P Tuberculosis

EYE, EAR, NOSE THROAT
C P Deafness
C P Earache
C P Enlarged glands
C P Enlarged thyroid
C P Eye pain
C P Hay fever
C P Sinus infection
C P Tinnitus
C P Tonsillitis

SKIN
C P Boils
C P Bruise easily
C P Dryness
C P Itching
C P Psoriasis
C P Rash
C P Eczema
C P Herpes
C P Hives or allergy
C P Varicose veins

PAIN OR NUMBNESS
C P Arms
C P Elbows
C P Hands
C P Hips
C P Legs
C P Knees
C P Feet

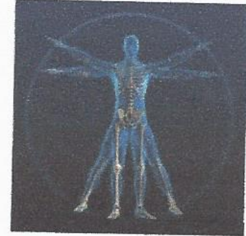
WOMEN
C P Cramps or backache
C P Painful menstruation
C P Lumps in breat
C P Menopause
C P Hot flashes

Are you pregnant? ☐ Yes ☐ No
If yes, how many months? __________
Number of children you have: ______
Number of pregnancies: __________

HABITS	None	Light	Mod.	Heavy
Water	☐	☐	☐	☐
Soft drinks	☐	☐	☐	☐
Coffee/black tea	☐	☐	☐	☐
Alcohol	☐	☐	☐	☐
Tobacco	☐	☐	☐	☐
Drugs	☐	☐	☐	☐
Sugar	☐	☐	☐	☐
Artif. sweetener	☐	☐	☐	☐
Salty foods	☐	☐	☐	☐
Appetite	☐	☐	☐	☐
Exercise	☐	☐	☐	☐
Sleep	☐	☐	☐	☐

Client signature: ______________________________ Date: __________________

Cornerstone Therapeutic: Massage Therapy Client Consent Form



THIS FORM MUST BE COMPLETED & SIGNED BEFORE RECEIVING A MASSAGE.
In addition to your Health History Information

Have you ever experienced a professional massage? ______________________________

Which areas would you like to focus on during this massage? ______________________________

Note: A massage therapy session is an experience jointly created by the therapist and the client. Working together, massage encourages stress relief and body awareness. Your therapist will listen and respond to your words and to the tissues in your body to create a safe, healthy and supportive experience. All sessions are client centered — your comfort and well-being is the highest priority.

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 the session, I will immediately inform the therapist so that the pressure and/or strokes may be adjusted to my level of comfort. I further understand that massage should not be construed as a substitute for a medical examination, diagnosis, or treatment. I understand that massage therapists 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.

It is necessary for the practitioner to touch and observe my body in order to conduct this process. I am aware that this work is performed directly on the skin with the use of lubricants, and that all areas of my body not being treated will remain draped. I give the practitioner full permission to work on my body in such a way.

Reactions that can occur include, but are not limited to, the following:

Common reactions
- ☐ Increased urination
- ☐ Flatulence and more frequent bowel movements
- ☐ Outbreak of sweat in the palms, feet or other body areas
- ☐ Increased secretion in mucous membranes
- ☐ Increased vaginal secretions and discharge
- ☐ Disrupted sleep patterns
- ☐ Tiredness

Less common reactions
- ☐ Headaches
- ☐ Dizziness
- ☐ Emotional release, tendency to weep
- ☐ Temporary outbreak of suppressed diseases
- ☐ Aggravated skin conditions (pimples)
- ☐ Chilliness
- ☐ Inner shivering, chattering of the teeth, spasms

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 massage therapist updated as to any changes in my medical profile during the session and understand that there shall be no liability on the massage therapists part should I fail to do so. I understand that any illicit or sexually suggestive remarks or advances made by me will result in immediate termination of the session. I also understand that the License Massage Therapist reserves the right to refuse to perform massage on anyone whom he/she deems to have a condition for which massage is contraindicated. If you have a specific medical condition or specific symptoms in which massage is contraindicated, you may be referred to another appropriate healthcare provider. In this case massage cannot be continued without appropriate written consent from primary care physician or provider.

In my role as client: it is my responsibility to: A.) Arrive for sessions on time; notify the practitioner at least 24 hours in advance if I need to change or cancel an appointment. There will be a first time grace for cancellation or no call / no show within 24 hours. Missed or no-show appointments will result in your being charged the full amount of the session booked unless the appointment can be filled. Depending on our booking schedule, late appointments may not receive the full session time allotted for the treatment service booked: Full payment is still required. Emergency cancellations are determined at the Massage Therapist's discretion. B.) Provide information on my health status on the forms provided, and keep the practitioner updated as to changes in my health status.

Payment Policy
All services are rendered on a fee for service basis. You are expected to pay for services on the day that care is given. You may pay by cash, check, credit card and gift certificate.

Client Signature ____ Date _______________

All client information is held strictly confidential except where required by law under the Health Insurance Portability & Accountability Act of 1996 (HIPAA).