# KMS Massage & Holistic Therapies, LLC

Client Health History Form

Date_____

Full Name_____

Email Address_____

Address_____

City_____State_____Zip_____

Phone Number_____Cell_____

Date of Birth_____Occupation_____Employer_____

Referred By_____How did you hear of me?_____

Previous experience with massages_____

Primary reason for appointment (ie, areas of pain or tension)_____

Emergency Contact (EC)_____

Phone & Relationship with EC_____

Please mark **(X)** all conditions that apply **now,** mark **(P)** for **past** conditions:

| | | |
|---|---|---|
| _____Headaches/Migraines | _____Sinus Problems | _____Hernia |
| _____Vision Problems/Contacts | _____Dental Bridges/TMJ | _____Abdominal/Digestive Issues |
| _____Hearing Problems/Deafness | _____Asthma | _____Chronic Pain |
| _____Injuries to Face or Head | _____Constipation/Diarrhea | _____Muscle or Joint Pain |
| _____Muscle/Bone Injuries | _____Numbness/Tingling | _____Sprains/Strains |
| _____Arthritis/Tendonitis | _____Cancer/Tumor | _____Diabetes |
| _____Pregnancy | _____Fatigue | _____Heart/Circulatory Problems |
| _____Tension/Stress | _____Depression | _____Sleep Difficulties |
| _____Allergies/Sensitivity | _____Rash/Athletes Foot | _____Infectious Disease |
| _____Blood Clots | _____Varicose Veins | _____Anemia |
| _____High/Low Blood Pressure | _____Phlebitis | _____Car Accident /Trauma |
| _____Ruptured/Bulging Disc | _____Auto Immune Disorder | _____Fibromyalgia |
| _____Osteoporosis | _____Emphysema | _____Implants |
| _____Pacemaker | _____Gout | _____Other:_____ |

Explain any conditions marked above:_____

_____

Previous surgeries with an approximate date:_____

_____

Previous injuries, including broken bones, not requiring surgery:_____

_____

Medications:

_____Vitamins _____Herbs _____Pain Reducers _____Anti-anxiety

_____Sleeping Pills _____Anti-depressants _____Muscle Relaxants

Other:_____

Please circle the one that applies to you:

What are your most frequent activities at work & home? Sitting Standing Lifting

Healthy diet? Always Frequently Sometimes Infrequently Rarely

Adequate Sleep? Every Night Most Nights Difficulty Sleeping Use Sleep Aids

**Informed Consent: Please take a moment to carefully read the following and sign where indicated.**
The above information is accurate to the best of my knowledge and I freely give my permission to be massaged. Since massage is contraindicated for some serious medical conditions, it may be necessary to obtain a doctor's release or prescription before beginning therapy. I agree to inform the therapist of any experience of pain during the session. I understand massage does not deter me from seeking medical treatment for medical conditions. I understand that no inappropriate comments or conduct will be tolerated. Any indication of such behavior will automatically end the session with full payment.
I agree to update the massage therapist in regard to changes in my health and understand that there shall be no liability on the therapist's part should I forget to do so. I agree to hold harmless the establishment, all management, including volunteers, from and against any and all claims. I agree to handle suit at its sole expense and agree to bear all costs related even if claims, etc., are groundless, false, and fraudulent.

*If I am using an expired Gift Certificate, I understand that 10% per month past expiration date will be deducted from total of gift certificate, and balance will be due upon redemption of service. Lastly, should I have to cancel an appointment for any reason I agree to give the therapist a 24-hour notice. Failure to do so may result in a charge to my credit card. Failure to do so three (3) consecutive times will result in prepayment or failure to book any future appointments. I agree and fully understand the above information and consent.* _____ Initial

Client Signature_____Date_____

Therapist Signature_____Date_____