

## CLIENT HEALTH HISTORY

Date: \_\_\_\_\_ Phone: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

First Name: \_\_\_\_\_ Last Name: \_\_\_\_\_ ("Client")

Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Email Address: \_\_\_\_\_ May we add you to our Email list? Yes No  
(Please note that your Email will not be shared with anyone outside of Eastern Sun Therapeutics and you may unsubscribe at any time.)

How did you hear about us? \_\_\_\_\_

Emergency Contact: \_\_\_\_\_ Relationship: \_\_\_\_\_ Phone: \_\_\_\_\_

Have you ever had a massage? Yes No If so, when was your last massage \_\_\_\_\_

Are you allergic to any lotions or perfumes? Yes No If so, please specify \_\_\_\_\_

Are you allergic to any nut oils or avocado oil? Yes No

Do you prefer a specific type of massage? Yes No If so, please specify or circle the appropriate modality.  
\_\_\_\_\_  
Swedish, Neuromuscular, Deep Tissue, Orthopedic, Sports, Trigger Point Therapy,  
Myofascial Release, Breath Awareness, Abdominal, Diaphragm.

Do you prefer quiet during your massage or is conversation welcome? Yes No Do you prefer to initiate  
conversation? Yes No Would you like your therapist to explain issues found during your massage or after  
the completion of the massage? During After (We respect your need to unwind and relax even while receiving medically  
based treatment massage so please let us know if you would like a summary of your treatment after or during your session.)

Surgeries and Dates: \_\_\_\_\_

\_\_\_\_\_

Injuries and Dates: \_\_\_\_\_

\_\_\_\_\_

Car Accidents and Dates: \_\_\_\_\_

Internal wires, pins, rods, artificial joints or special equipment: \_\_\_\_\_

Are you currently under the care of a physician or mental health care provider? Yes No If yes, please explain:

\_\_\_\_\_

Current medications and/or supplements you take and those taken within the past 24 hours: \_\_\_\_\_

\_\_\_\_\_

Please check any current or past health conditions listed below.

- |   |  |
|---|--|
| <input type="checkbox"/> phlebitis                                | <input type="checkbox"/> contagious skin condition   |
| <input type="checkbox"/> deep vein thrombosis/blood clots         | <input type="checkbox"/> open sores or wounds        |
| <input type="checkbox"/> joint disorder/rheumatoid                | <input type="checkbox"/> easy bruising               |
| <input type="checkbox"/> arthritis/osteoarthritis/tendonitis      | <input type="checkbox"/> recent accident or injury   |
| <input type="checkbox"/> osteoporosis                             | <input type="checkbox"/> recent fracture _____       |
| <input type="checkbox"/> epilepsy                                 | <input type="checkbox"/> recent surgery _____        |
| <input type="checkbox"/> headaches/migraines                      | <input type="checkbox"/> artificial joint            |
| <input type="checkbox"/> cancer _____                             | <input type="checkbox"/> sprains/strains _____       |
| <input type="checkbox"/> diabetes                                 | <input type="checkbox"/> swollen glands _____        |
| <input type="checkbox"/> decreased sensation                      | <input type="checkbox"/> allergies/sensitivity _____ |
| <input type="checkbox"/> back/neck problems                       | <input type="checkbox"/> heart condition             |
| <input type="checkbox"/> Fibromyalgia                             | <input type="checkbox"/> high or low blood pressure  |
| <input type="checkbox"/> TMJ Dysfunction                          | <input type="checkbox"/> circulatory disorder        |
| <input type="checkbox"/> carpal tunnel syndrome                   | <input type="checkbox"/> varicose veins              |
| <input type="checkbox"/> tennis elbow                             | <input type="checkbox"/> atherosclerosis             |
| <input type="checkbox"/> pregnancy If yes, how many months? _____ |  |

Please explain any items checked above or any conditions not listed: \_\_\_\_\_

I, Client, 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 a 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 medical examination, diagnosis, or treatment and that I should see a physician, chiropractor or other qualified medical specialist for any mental or physical ailment that I am aware of. 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 a session 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 therapist updated as to any changes in my medical profile and understand that there shall be no liability on the therapist's or Eastern Sun Therapeutics' ("EST") part should I fail to do so. *Certain medical conditions require prior physician approval and EST reserves the right to refuse services, in its sole discretion, until such consent is received.*

All health information provided to EST is confidential and subject to HIPAA regulations. Health information will not be disclosed without your prior written consent.

Draping will be used during the session – only the area being worked on will be uncovered. You have the option to receive massage fully clothed. Please undress to your level of comfort. **Clients 17 years and under must be accompanied by a parent or legal guardian during the entire session. Informed written consent must be provided by a parent or legal guardian for any client under the age of 17.**

**Harassment:** EST adheres to strict professional guidelines of operation. Suggestive or sexual behavior of any sort will not be tolerated. In the event that this behavior is present, your massage therapist reserves the right to terminate the appointment immediately, to charge the full cost of the service scheduled, and to refuse to book future sessions. Harassment is a serious issue and will be treated as such.

\_\_\_\_\_  
Client Signature

\_\_\_\_\_  
Massage Therapist Signature

\_\_\_\_\_  
Client Printed Name

\_\_\_\_\_  
Massage Therapist Printed Name

\_\_\_\_\_  
Date

\_\_\_\_\_  
Date