Eastern Sun Therapeutics, LLC
Harmonizing Body & Mind

4340 E Kentucky Ave, Suite 447
Glendale, CO 80246
Phone: (303) 324-9742

# CLIENT HEALTH HISTORY

Date: _____

First Name: _____ Last Name: _____("Client") Date of Birth: _____

Address: _____ City: _____ State: _____ Zip: _____ Phone: _____

Email Address: _____ May we add you to our e-mail list? ☐Yes ☐No
(Your e-mail 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

Is conversation welcome during your massage? ☐Yes ☐No

Do you prefer to initiate conversation? ☐Yes ☐No

Would you like your therapist to explain any 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 are taking, and those taken in the past 24 hours:
_____
_____

Please check any current or past health conditions listed below.

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

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 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 LLC's ("EST") part should I fail to do so. *Certain medical conditions require prior physician/psychotherapist 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 will be uncovered. You have the option to receive massage fully clothed. Please undress to your level of comfort. **Clients 17 years and under, and mentally impaired clients, 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, or for any mentally impaired clients.**

**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 |