Eastern Sun Therapeutics, LLC
Harmonizing Body & Mind

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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
(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, jojoba, lanolin, linalool 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 issues found during your massage or after the completion of the massage?
☐During ☐After

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.

( ) 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 Dysfunction
( ) 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____________________________
( ) swollen glands____________________________
( ) allergies/sensitivity________________________
( ) heart condition
( ) high or low blood pressure
( ) circulatory disorder
( ) varicose veins
( ) atherosclerosis

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 physical or mental 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 will 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 the therapist/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.

LIABILITY WAIVER: **I understand that, because massage therapy work involves maintained touch and close physical proximity over an extended period of time, there may be an elevated risk of disease transmission, including COVID-19. By signing below, I acknowledge that I am aware of the risks involved in receiving treatment at this time, I voluntarily agree to assume those risks, and I release and hold harmless Eastern Sun Therapeutics, LLC and Stephanie Boschen, personally, from any claims, whatsoever, related thereto. I give my consent to receive treatment from Stephanie Boschen.**

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