YJ Massage

Consent and Confidential Health Form

An accurate health history is important to ensure that it is safe for you to receive a massage treatment. All information gathered for this treatment is confidential except as required by law or except to facilitate assessment or treatment. If your health status changes in the future, please contact us and let us know. You will be asked to provide written authorization for release of any information.

Personal Information

Name:_____Date of Birth (mm/dd/yy):_____Gender: M / F

Home Phone:_____Cell Phone:_____Work Phone:_____

Address:_____City:_____Postal Code:_____

e-mail:_____Occupation:_____First Massage: Y / N

Family Physician:_____Emergency Contact:_____

How did you hear about us? Who referred you:_____

Health History

Please check all that apply to you

Soft Tissue/Joints:
- ☐ Tendonitis/Bursitis
- ☐ Weakness
- ☐ Sprains/strains
- ☐ Arthritis
- ☐ Fractures
- ☐ Herniated discs

Headaches
- ☐ Tension headaches
- ☐ Migraines
- ☐ Tooth/Jaw/Ear pain
- ☐ Head trauma

Accident/Injury
- ☐ Car accident
- ☐ Whiplash

Women
- ☐ Pregnant/Due date_____
- ☐ Gynecological conditions

Respiratory
- ☐ Chronic cough
- ☐ Shortness of breath
- ☐ Bronchitis
- ☐ Asthma
- ☐ Emphysema
- ☐ Pneumonia
- ☐ Sinus problems

Cardiovascular
- ☐ High blood pressure
- ☐ Low blood pressure
- ☐ Heart attack
- ☐ Phlebitis
- ☐ Stroke / CVA
- ☐ Pacemaker
- ☐ Heart disease
- ☐ Angina
- ☐ Chronic congestive heart failure

Infectious Disease
- ☐ Hepatitis A/B/C
- ☐ Tuberculosis
- ☐ HIV/AIDS

Skin
- ☐ Bruise easily
- ☐ Herpes
- ☐ Varicose veins
- ☐ Athletes foot
- ☐ Warts
- ☐ Eczema

General Conditions
- ☐ Neurological conditions
- ☐ Epilepsy
- ☐ Diabetes
- ☐ Allergies _____
- ☐ Anaphylaxis
- ☐ Cancer
- ☐ Vision problems
- ☐ Hearing loss
- ☐ Constipation
- ☐ Insomnia
- ☐ Kidney/Bladder problems
- ☐ Hemophilia
- ☐ Fibromyalgia
- ☐ Osteoporosis
- ☐ Surgical implants_____

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Additional Information

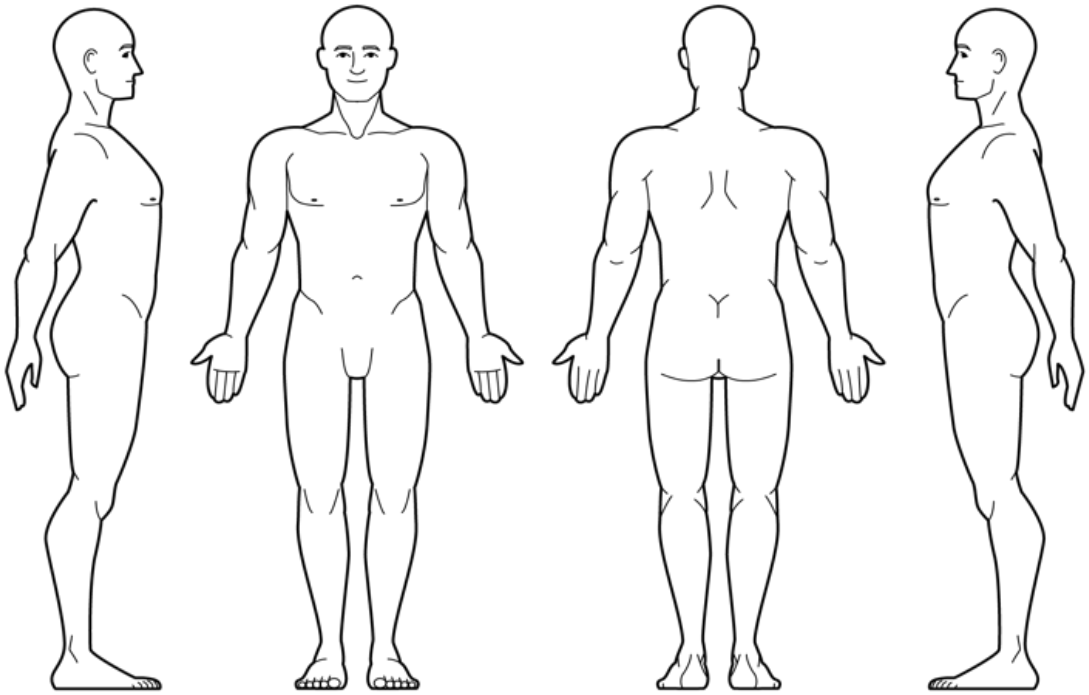
Major Surgery/Other Conditions:_____

Current Medication:_____

Areas you do not want massaged:_____

Reason for massage therapy:_____General Heath Status: Excellent / Good / Fair / Poor

Please circle any areas of discomfort:



Consent for Treatment

I have read and thoroughly understand all the above form. The information given is correct and complete to my knowledge. I shall notify the therapist upon any changes or updates of my health or medication, so my file information remains current. I am seeking massage therapy on my own accord for the purposes that the massage is intended. I understand that the massage therapist is not responsible to diagnose illness, prescribe medications or make spinal adjustments. I will communicate information (such as pain/discomfort levels) throughout the session to ensure my own safety and the effectiveness of the session. I understand YJ Massage do not accept liability for any claim as to the method or manner of treatment given, or any complaint and accident related to the treatments given. The therapist reserves the right to reject customers and end the massage treatment at any time. I fully understand and agree to the above disclaimer and give my consent.

Client Signature:_____ Date:_____