Salon Indulgence
Day Spa & Boutique 920.788.2812
133 E. Main Street Little Chute, WI.

HEALTH HISTORY FORM

Today's Date:_____ Date of Initial Visit: _____
Name: _____Telephone #(Home) _____
Address: _____ (Day) _____
City: _____State: _____Zip: _____ (Cell) _____
Email: _____ Date of Birth: _____
Occupation: _____ Referred by: _____
Emergency Contact Name: _____ Phone: _____

Are you currently consulting with any healthcare practitioner? _____
If so, why? _____
Have you ever received a professional massage? Yes/No If yes, frequency_____
What is your main area of concern or pain? _____
What types of massage/bodywork do you prefer?_____
What kind of pressure do you prefer? Light Medium Firm
What are your goals/expected outcomes for receiving massage/bodywork?
_____
_____
How do you feel today? _____
List and prioritize your current symptoms/issues (stress, pain, stiffness, numbness/tingling, swelling, etc.):
_____
_____
Do these symptoms interfere with your activities of daily living (e.g., sleep, exercise, work, childcare)?
Yes / No Explain: _____
_____
Please circle areas of your body that you give permission to receive massage:
Back Legs Buttocks Arms Abdomen Chest Neck Head Face Feet Other_____
Have you consumed alcohol within the past 24 hours? Yes/No How much? _____
Are you wearing contacts? Yes / No
Are you wearing dentures? Yes / No
Are you wearing a hairpiece? Yes / No
Are you pregnant? Yes / No
Please list and explain all medications including aspirin and herbal remedies that you are currently taking:
_____
_____
Please list all accidents, injuries, and illnesses:
_____
_____
List stress reduction and exercise activities; include frequency:
_____
_____

Please check all that apply:

MUSCULO-SKELETAL

___bone or joint disease_____
___broken/fractured bones_____
___arthritis_____
___tendonitis/bursitis_____
___lupus_____jaw pain_____TMJ_____
___sprains/strains_____
___low back, hip, leg pain_____
___neck, shoulder, arm pain_____
___headaches/head injuries_____
___spasms/cramps_____
___pins/plates or surgical implants_____
___other_____

CIRCULATORY/RESPIRATORY

___heart disease/condition_____
___vericose veins_____
___blood clots_____
___lymphedema_____
___asthma/breathing difficulty_____
___other_____

OTHER

___diabetes: Type1_____ Type 2_____
___contacts ___dentures ___glasses ___wigs
___hearing aids_____
___glaucoma_____
___cancer/tumors_____
___prosthetics_____
___depression_____
___vision disturbance (blurring, blind spots, etc.)___
_____
___use of caffeine, nicotine, drugs, alcohol_____

SKIN

___allergies (nuts, seafood, latex)_____
___rashes_____
___athletes foot ___warts_____
___other_____

DIGESTIVE

___constipation_____
___gas/bloating_____
___diverticulitis_____
___irritable bowel syndrome_____
___abdominal pain_____
___gastric/acid reflux_____
___other_____

NERVOUS SYSTEM

___herpes/shingles_____
___numbness/tingling_____
___chronic pain_____
___chronic fatigue_____
___sleep disorders_____
___changes in consciousness (seizure/fainting)_____
___multiple sclerosis_____
___peripheral neuropathy_____
___nerve compression_____
___other_____

REPRODUCTIVE/URINARY

___pregnant? Stage_____
___PMS_____
___kidney/urinary infection_____
___other_____

INFECTIOUS DISEASE

___disease name(s)_____

It is my choice to receive massage therapy. I realize that the treatment is being given for the well-being of my body and mind. This includes stress reduction, relief from muscular tension, spasm or pain, or for increasing circulation or energy flow. I agree to communicate with my practitioner any time I feel like my well being is being compromised.

I understand that massage practitioners do not diagnose illness, disease, or any physical or mental disorder, nor do they prescribe medical treatment, pharmaceuticals, or perform spinal thrust manipulation. I acknowledge that massage is not a substitute for medical examination or diagnosis, and that it is recommended that I see a primary health care provider for that service.

I have stated all medical conditions that I am aware of and will update the massage practitioner of any changes in my health status.

SIGNATURE_____ DATE_____