



**Peaceful Mind and Body Oasis, LLC  
Massage Therapy Center**

**Client Health History Form  
Confidential**

**Client Information**

Name: \_\_\_\_\_

Date: \_\_\_\_\_

Address: \_\_\_\_\_

Telephone #: \_\_\_\_\_

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

Gender: Male \_\_\_\_\_ Female \_\_\_\_\_

Email Address: \_\_\_\_\_

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

Emergency Contact: \_\_\_\_\_

Your Occupation: \_\_\_\_\_

Emergency Contact phone #: \_\_\_\_\_

**General Questions**

How you ever had a therapeutic massage? If yes, how often? \_\_\_\_\_

What are your goals for today's massage? \_\_\_\_\_

**Health Information**

Are you currently under the care of a physician? \_\_\_\_\_ Yes \_\_\_\_\_ No If yes, please indicate the condition for which you are being treated \_\_\_\_\_

Please list any medications you are currently taking \_\_\_\_\_

Have you had any surgeries?  Yes  No If yes, please list. \_\_\_\_\_

Have you had any injuries or accidents?  Yes  No If yes, please list \_\_\_\_\_

Are you pregnant or trying to become pregnant?  Yes  No If you are pregnant, please identify which trimester and if there are any associated conditions \_\_\_\_\_

In order to provide you with appropriate and client centered massage, we need an accurate health history. Please check any that apply and explain below.

Skin Condition

Stroke

Immune System

Blood Clots (DVT)

Diabetes

Deficiency

High Blood Pressure

Cancer or Tumors

Arthritis

Congestive Heart Failure

Kidney or Urinary  
problems

Osteoporosis

Heart Attack

Respiratory problems

Fibromyalgia

Other Cardiovascular

Infectious Disease

Numbness or Tingling

Disease

Other

Explanation(s) \_\_\_\_\_

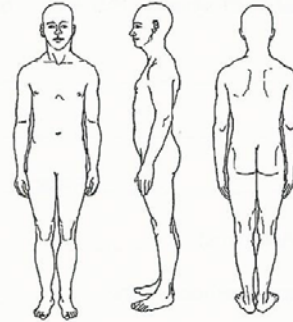
\_\_\_\_\_

\_\_\_\_\_

On a scale of 0 (no stress) to 10 (high levels of stress)  
Please indicate the general amount of stress in your life. 0 \_\_\_\_\_ 10

On the figures to the right, please indicate the following areas:

- Where you carry tension (T)
- Areas of discomfort or pain (D)
- Where you hold your stress (S)



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The following sometimes occurs during massage. They are normal responses to relaxation. Trust your body to express what it needs to:  
need to move or change position \*sighing \* yawning \* change in breathing  
stomach gurgling \* emotional feelings and/or expression  
movement of intestinal gas \* energy shifts \* falling asleep \* memories

I hereby acknowledge that all of the above information is correct and if I have any changes in my health I will let the massage therapist know.

The massage/bodywork received today is provided for the purpose of relaxation and relief of muscular tension. Peaceful Mind and Body Oasis, LLC reserves the right to refuse massage treatment to any individual for any reason, including inappropriate behavior, illicit or sexually suggestive remarks, abusive or threatening behavior, medical contraindications, repetitive cancellation, tardiness, ethical reasons, or if the individual is, or appears to be, under the influence of alcohol, or illegal drugs. Any actions that could reasonably be seen as sexual in nature, including sexual references, offensive language, or similar acts, will not be tolerated. The Massage therapist has the right to end the session immediately if any of these or other actions occur, and the client will still be responsible for the full payment of the fee.

If I experience any pain or discomfort during this 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 the session given 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 part should I fail to do so.

Signature of client \_\_\_\_\_ Date: \_\_\_\_\_