

**SYNERGY HEALING ARTS CENTER & MASSAGE SCHOOL, INC. HEALTH INFORMATION**

Client Name \_\_\_\_\_ Date \_\_\_\_\_

**A. Client Information**

Address \_\_\_\_\_  
City/State/Zip \_\_\_\_\_  
Phone: Home (\_\_\_\_)\_\_\_\_-\_\_\_\_\_  
Work (\_\_\_\_)\_\_\_\_-\_\_\_\_ Cell (\_\_\_\_)\_\_\_\_-\_\_\_\_\_

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

Height \_\_\_\_\_

**Employer**

Work Address \_\_\_\_\_  
Occupation \_\_\_\_\_  
Emergency Contact \_\_\_\_\_  
Phone: Home (\_\_\_\_)\_\_\_\_-\_\_\_\_\_  
Work (\_\_\_\_)\_\_\_\_-\_\_\_\_ Cell (\_\_\_\_)\_\_\_\_-\_\_\_\_\_

Weight – please check

Under 250 lbs

Over 250 lbs

Have you received massage therapy before?  
Frequency? \_\_\_\_\_

**Primary Health Care Provider**

Address \_\_\_\_\_  
City/State/Zip \_\_\_\_\_  
Phone: \_\_\_\_\_ Fax: \_\_\_\_\_

What are your goals for receiving massage therapy?  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

I give my massage therapist permission to consult with my health care providers regarding my health and treatment.

Comments \_\_\_\_\_  
Initials \_\_\_\_\_ Date: \_\_\_\_\_

**B. Current Health Information**

List Health Concerns. Check all that apply

Primary N/A  \_\_\_\_\_

mild  moderate  disabling

constant  intermittent

symptoms  ↑ w/activity  ↓ w/activity

getting worse  getting better  no change  
treatment received \_\_\_\_\_

Secondary N/A  \_\_\_\_\_

mild  moderate  disabling

constant  intermittent

symptoms  ↑ w/activity  ↓ w/activity

getting worse  getting better  no change  
treatment received \_\_\_\_\_

Additional N/A  \_\_\_\_\_

mild  moderate  disabling

constant  intermittent

symptoms  ↑ w/activity  ↓ w/activity

getting worse  getting better  no change  
treatment received \_\_\_\_\_

**C. Health History**

List and explain. Include dates and treatment received.

Surgeries N/A  \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Injuries N/A

Major illnesses N/A

List Current Medication & Herbal Remedies  
Medication Condition used for  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**PLEASE COMPLETE THE OTHER SIDE**

**PLEASE CHECK ALL CURRENT AND PREVIOUS CONDITIONS  
& LIST SPECIFIC MEDICATIONS**

<b>GENERAL</b>			<b>NERVOUS SYSTEM</b>			<b>ALLERGIES</b>		
<b>Current</b>	<b>Past</b>	<b>Medication</b>	<b>Current</b>	<b>Past</b>	<b>Medication</b>	<b>Current</b>	<b>Past</b>	<b>Medication</b>
<input type="checkbox"/>	<input type="checkbox"/>	headaches_____	<input type="checkbox"/>	<input type="checkbox"/>	head injuries_____	<input type="checkbox"/>	<input type="checkbox"/>	scents, oils_____
<input type="checkbox"/>	<input type="checkbox"/>	pain_____	<input type="checkbox"/>	<input type="checkbox"/>	Concussions_____	<input type="checkbox"/>	<input type="checkbox"/>	lotions_____
<input type="checkbox"/>	<input type="checkbox"/>	sleep disorders_____	<input type="checkbox"/>	<input type="checkbox"/>	loss memory/confusion_____	<input type="checkbox"/>	<input type="checkbox"/>	detergents_____
<input type="checkbox"/>	<input type="checkbox"/>	fatigue_____	<input type="checkbox"/>	<input type="checkbox"/>	dizziness_____	<input type="checkbox"/>	<input type="checkbox"/>	other_____
<input type="checkbox"/>	<input type="checkbox"/>	infections_____	<input type="checkbox"/>	<input type="checkbox"/>	ringing in ears_____	<b>DIGESTIVE/ELIMINATION SYSTEM</b>		
<input type="checkbox"/>	<input type="checkbox"/>	fever_____	<input type="checkbox"/>	<input type="checkbox"/>	sciatica shooting pain_____	<input type="checkbox"/>	<input type="checkbox"/>	bowel problems_____
<input type="checkbox"/>	<input type="checkbox"/>	sinus_____	<input type="checkbox"/>	<input type="checkbox"/>	chronic pain_____	<input type="checkbox"/>	<input type="checkbox"/>	gas, bloating_____
<input type="checkbox"/>	<input type="checkbox"/>	other_____	<input type="checkbox"/>	<input type="checkbox"/>	depression_____	<input type="checkbox"/>	<input type="checkbox"/>	bladder/kidney/prostrate_____
<b>MUSCLES AND JOINTS</b>			<b>RESPIRATORY, CARDIOVASCULAR</b>			<input type="checkbox"/>	<input type="checkbox"/>	abdominal pain_____
<input type="checkbox"/>	<input type="checkbox"/>	rheumatoid arthritis_____	<input type="checkbox"/>	<input type="checkbox"/>	heart disease_____	<input type="checkbox"/>	<input type="checkbox"/>	other_____
<input type="checkbox"/>	<input type="checkbox"/>	osteoarthritis_____	<input type="checkbox"/>	<input type="checkbox"/>	blood clots_____	<b>ENDOCRINE SYSTEM</b>		
<input type="checkbox"/>	<input type="checkbox"/>	osteoporosis_____	<input type="checkbox"/>	<input type="checkbox"/>	stroke_____	<input type="checkbox"/>	<input type="checkbox"/>	thyroid_____
<input type="checkbox"/>	<input type="checkbox"/>	scoliosis_____	<input type="checkbox"/>	<input type="checkbox"/>	lymphadema_____	<input type="checkbox"/>	<input type="checkbox"/>	diabetes_____
<input type="checkbox"/>	<input type="checkbox"/>	broken bones_____	<input type="checkbox"/>	<input type="checkbox"/>	high/low blood pressure_____	<input type="checkbox"/>	<input type="checkbox"/>	other_____
<input type="checkbox"/>	<input type="checkbox"/>	spinal problems_____	<input type="checkbox"/>	<input type="checkbox"/>	irregular heart beat_____	<b>REPRODUCTIVE SYSTEM</b>		
<input type="checkbox"/>	<input type="checkbox"/>	disk problems_____	<input type="checkbox"/>	<input type="checkbox"/>	poor circulation_____	<input type="checkbox"/>	<input type="checkbox"/>	pregnancy_____
<input type="checkbox"/>	<input type="checkbox"/>	lupus_____	<input type="checkbox"/>	<input type="checkbox"/>	swollen ankles_____	<input type="checkbox"/>	<input type="checkbox"/>	PMS_____
<input type="checkbox"/>	<input type="checkbox"/>	TMJ, jaw pain_____	<input type="checkbox"/>	<input type="checkbox"/>	varicose veins_____	<input type="checkbox"/>	<input type="checkbox"/>	fibrotic cysts_____
<input type="checkbox"/>	<input type="checkbox"/>	spasms, cramps_____	<input type="checkbox"/>	<input type="checkbox"/>	chest pain_____	<input type="checkbox"/>	<input type="checkbox"/>	other_____
<input type="checkbox"/>	<input type="checkbox"/>	sprains, strains_____	<input type="checkbox"/>	<input type="checkbox"/>	shortness of breath_____	<b>CANCER/TUMORS</b>		
<input type="checkbox"/>	<input type="checkbox"/>	tendonitis, bursitis_____	<input type="checkbox"/>	<input type="checkbox"/>	asthma_____	<input type="checkbox"/>	<input type="checkbox"/>	benign_____
<input type="checkbox"/>	<input type="checkbox"/>	stiff/painful joints_____	<input type="checkbox"/>	<input type="checkbox"/>	other_____	<input type="checkbox"/>	<input type="checkbox"/>	malignant_____
<input type="checkbox"/>	<input type="checkbox"/>	weak/sore muscles_____	<b>SKIN CONDITIONS</b>			<input type="checkbox"/>	<input type="checkbox"/>	other_____
<input type="checkbox"/>	<input type="checkbox"/>	neck/shoulder/arm pain_____	<input type="checkbox"/>	<input type="checkbox"/>	rashes_____	<b>HABITS</b>		
<input type="checkbox"/>	<input type="checkbox"/>	low back/hip/leg pain_____	<input type="checkbox"/>	<input type="checkbox"/>	athlete's foot, warts_____	<input type="checkbox"/>	<input type="checkbox"/>	tobacco_____
<input type="checkbox"/>	<input type="checkbox"/>	other_____	<input type="checkbox"/>	<input type="checkbox"/>	other_____	<input type="checkbox"/>	<input type="checkbox"/>	alcohol_____
<b>Contract for Care</b>			<b>SKIN CONDITIONS</b>			<input type="checkbox"/>	<input type="checkbox"/>	drugs_____
<b>Contract for Care</b>			<input type="checkbox"/>	<input type="checkbox"/>	athlete's foot, warts_____	<input type="checkbox"/>	<input type="checkbox"/>	coffee, soda_____
<b>Contract for Care</b>			<input type="checkbox"/>	<input type="checkbox"/>	other_____	<input type="checkbox"/>	<input type="checkbox"/>	other_____

I promise to participate fully as a member of my health care team. I will make sound choices regarding my treatment plan based on the information provided by my massage therapist and other members of my health care team, and my experience of those suggestions. I agree to Participate in the self-care program we select. I promise to inform my practitioner any time I feel my well-being is threatened or compromised. I expect my massage therapist to provide safe and effective treatment.

**Consent for Care**

It is my choice to receive massage therapy. I give my consent to receive treatment. I have reported all health conditions that I am aware of and will inform my practitioner of any changes in my health. I have read and understand this form in entirety. I understand that all therapists located at SHACMS, Inc. are independent contractors and not employees of SHACMS, Inc. and I agree to release SHACMS, Inc. of any and all liability for any injuries, claims, or damages arising out of any services which I receive from independent contractors at SHACMS, Inc.

Signature: \_\_\_\_\_ Date: \_\_\_\_\_ Email: \_\_\_\_\_

