THERAPEUTIC MASSAGE AND NUTRITION CENTER
2456 N. WOODLAWN, SUITE 1A, WICHITA, KS 67220
(316) 425-8003

CLIENT HEALTH HISTORY

NAME: _____ DATE: _____
ADDRESS: _____ CITY: _____ STATE: _____ ZIP: _____
HOME PHONE: _____ MOBILE PHONE: _____ WORK PHONE: _____
EMAIL: _____ DATE OF BIRTH: _____ AGE: _____ SEX: _____
EMERGENCY CONTACT: _____ EMERGENCY CONTACT PHONE: _____
OCCUPATION: _____ PHYSICIAN: _____
CURRENT MEDICATIONS: _____
SUPPLEMENTS: _____ (DRUG) ALLERGIES: _____
ARE YOU CURRENTLY UNDER DOCTOR CARE OR HAVE YOU SEEN A DOCTOR IN THE LAST 12 MONTHS? _____
IF YES, FOR WHAT REASON(S)? _____
HOW DID YOU HEAR ABOUT OUR OFFICE? _____

Please mark the conditions that apply to your **personal health history**:

- ☐ Heart disease
- ☐ High blood pressure
- ☐ Low blood pressure
- ☐ Varicose veins
- ☐ Blood clotting
- ☐ Circulatory disorders
- ☐ Stroke
- ☐ Skin condition
- ☐ Allergies
- ☐ Asthma
- ☐ Cancer
- ☐ Epilepsy/seizures
- ☐ Multiple Sclerosis
- ☐ Pregnant
- ☐ Osteopenia/Osteoporosis
- ☐ Scoliosis
- ☐ Migraine headaches
- ☐ TMJ dysfunction
- ☐ Neck pain
- ☐ Shoulder pain
- ☐ Mid/low back pain
- ☐ Sciatica
- ☐ Hip/knee pain
- ☐ Bulging disc
- ☐ Thyroid disease
- ☐ Diabetes
- ☐ Hypoglycemia
- ☐ CTS
- ☐ TOS
- ☐ Fever within 24 hours
- ☐ Communicable disease
- ☐ HIV virus
- ☐ Hospitalization Date(s): _____
- ☐ Injury Date(s): _____
- ☐ Other _____
- ☐ Other _____

AGREEMENT

_____ (initial) I understand that all services are rendered on a cash, check or credit card basis. Unless other arrangements have been made, I agree to pay for each session at the time of the session. I also agree to the $20 returned check charge in the event that my check is returned.

_____ (initial) Cancellation policy – I understand that any appointment not cancelled more than 12 hours prior to the scheduled time will be billed in full. There will be one "grace" given for one missed/late cancelled appointment.

_____ (initial) The information I have provided is truthful and complete to the best of my knowledge. I assume responsibility for advising the therapist of any changes in my condition. Should I experience pain or discomfort during a massage, I will immediately inform the therapist.

_____ (initial) I understand that the Therapeutic Massage Center does not diagnose or prescribe and is not a substitute for physician diagnosis and treatment.

_____ (initial) I understand that the HIPPA policy of this office will not allow for any transfer of personal information without written/signed consent of the client.

Client Signature: _____ Date: _____

(For Minor) Parent/Guardian Signature: _____ Date: _____