

**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**:

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

**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: \_\_\_\_\_