Tranquility...for you massage therapy

Health History Form

Please take a moment to fill out this confidential health history form. This will ensure that you receive proper treatment and that it is safe for you to do so. Thank you.

Name (please print) _____ Date _____
Address _____ City _____ State _____ Zip _____
Phone (Home) _____ (Business) _____ (Cell) _____
How did you hear about us? _____
Where may we email you? _____
Emergency Contact Name _____
Emergency Contact Phone _____Emergency Contact Relationship _____
Date of Birth _____/_____/_____ Sex M F
Occupation _____ Regular Hobbies/Activities _____
Have you been in a recent car accident or work related injury which is causing you discomfort? Y N
If yes, please explain _____
Have you had a massage before today? Y N If yes, most recent? _____
What type of pressure do you prefer? Light Medium Deep
Where in your body do you feel stress/tension/pain? _____
Using the scale below, how would you rate your discomfort?
Today (no pain) 0 1 2 3 4 5 6 7 8 9 10 (worst pain imaginable)
Typical Day (no pain) 0 1 2 3 4 5 6 7 8 9 10 (worst pain imaginable)
Can you describe it? Dull Sharp Shooting Achy Numb Tingling Stiff
Does anything aggravate your symptoms? _____
Does anything relieve your symptoms? _____
When did your symptoms begin? _____
Is this condition interfering with: Work Sleep Daily Activities
Please explain _____
Have you seen any other health care practitioners concerning this discomfort?
Medical Chiropractor Physiotherapist Massage Therapist Other
Have they provided any results? Y N
Do you have internal pins/wires/artificial joints? Y N If yes, please explain _____
Do you exercise? Y N If yes, frequency _____
Have you suffered from any serious illnesses or injuries (past or present?) Y N If yes, please explain
_____
Do you have any ongoing chronic conditions? Y N If yes, please explain _____
Please list any medications or supplements you are currently taking _____
Do you have any allergies to oils, lotions, scents? Y N If yes, please explain _____

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Please check all that apply.

HEAD/NECK
- ☐ Headache
- ☐ Migraine
- ☐ Visual Problems
- ☐ Contacts/Glasses
- ☐ Ear Aches
- ☐ Hearing Problems
- ☐ Jaw Pain/Dental Problems
- ☐ Whiplash

CARDIOVASCULAR
- ☐ High Blood Pressure
- ☐ Low Blood Pressure
- ☐ Chronic Congestive Heart Failure
- ☐ Poor Circulation
- ☐ Phlebitis
- ☐ Heart Disease

DIGESTIVE/UNRINARY
- ☐ Difficult Digestion
- ☐ Constipation
- ☐ Liver/Gallbladder
- ☐ Kidney/Urinary
- ☐ Diabetes (Type & Onset)
- ☐ Hypoglycemia
- ☐ Crohn's Disease
- ☐ Irritable Bowel Syndrome
- ☐ Ulcers

FEMALE
- ☐ Menstrual Problems
- ☐ Pregnancy
  Due Date
  _____
- ☐ Menopausal Problems
- ☐ Gynecological Problems

SKIN
- ☐ Bruise Easily
- ☐ Eczema
- ☐ Psoriasis
- ☐ Sensitivity
- ☐ Skin Condition (Please Specify)
  _____

MUSCLE/JOINT
- ☐ Neck
- ☐ Lower Back
- ☐ Mid Back
- ☐ Upper Back
- ☐ Shoulder
- ☐ Hip
- ☐ Knee
- ☐ Ankle
- ☐ Other
  _____
- ☐ Limited Range of Motion:
  _____

RESPIRATORY
- ☐ Asthma
- ☐ Chronic Cough
- ☐ Shortness of Breath
- ☐ Bronchitis
- ☐ Emphysema
- ☐ Smoker

INFECTIOUS CONDITIONS
- ☐ Tuberculosis
- ☐ AIDS/HIV
- ☐ Hepatitis: Type _____
- ☐ Infectious Skin Conditions (Explain)
  _____

OTHER
- ☐ Varicose Veins
- ☐ Stroke
- ☐ Heart Attack
- ☐ Loss of Sensation (Describe)
  _____
- ☐ Hemophiliac
- ☐ Epilepsy
- ☐ Pacemaker
- ☐ Athlete's Foot
- ☐ Arteriosclerosis
- ☐ Cold Sores
- ☐ Cancer
- ☐ Irregular Heart Beat
- ☐ Plantar Warts
- ☐ Anemia
- ☐ Arthritis

FAMILY HISTORY
- ☐ Fibromyalgia
- ☐ Osteoporosis
- ☐ Chronic Fatigue Syndrome
- ☐ Scoliosis
- ☐ Carpel Tunnel Syndrome
- ☐ Fainting/Dizziness/Loss of Consciousness
- ☐ Hernia
- ☐ Restless Leg Syndrome

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I understand that any massage therapy given here is for the purpose of stress reduction or spasm, and for increasing circulation and energy flow. Massage/bodywork should not be performed if you have certain medical conditions or specific symptoms. A referral from your primary care provider may be required prior to service being provided. If I experience any pain or discomfort during my session(s), I will immediately inform the practitioner so the pressure and/or strokes may be adjusted to my level of comfort. I further understand that massage/bodywork should not be construed as a substituted for medical examination, diagnoses or treatment, and that I should seek a physician or other qualified medical specialist for any mental or physical ailment I am aware of. I understand that massage practitioners are not qualified to perform spinal adjustments, diagnose, prescribe, or treat any physical or mental illness, and nothing said in the course of the session given should be construed as such. Because massage/bodywork should not be performed under certain medical conditions, I affirm that I have stated all of my known medical conditions and answered all questions honestly. I agree to keep the practitioner updated as to any changes in my medical profile and understand that there shall be no liability on the practitioner's part should I fail to do so. It is also understood that any illicit or sexually suggestive remarks or advances made by me will result in immediate termination of the session, and will be liable for full payment of the scheduled appointment.

I consent for my treatment by a certified/licensed massage therapist. I also acknowledge the policy that appointments cancelled with less than 24 hours notice may be subject to a $25 charge.

Client Signature _____ Date _____

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COMPLEMENTARY AND ALTERNATIVE HEALTH CARE CLIENT BILL OF RIGHTS

You are entitled to information regarding the degree, training, experience or other qualifications of the practitioner providing service to you. This information will be provided to you in written form before each massage you receive from a different therapist at Tranquility for you.

THE STATE OF MINNESOTA HAS NOT ADOPTED ANY EDUCATIONAL AND TRAINING STANDARDS FOR UNLICENSED COMPLEMENTARY AND ALTERNATIVE HEALTH CARE PRACTITIONERS. THIS STATEMENT OF CREDENTIALS IS FOR INFORMATIONAL PURPOSES ONLY.

1. Under Minnesota law, an unlicensed complementary and alternative health care practitioner may not provide a medical diagnosis or recommend discontinuance of medically prescribed treatments. If a client desires a diagnosis from a licensed physician, chiropractor, or acupuncture practitioner, or services from a physician, chiropractor, nurse, osteopath, physical therapist, dietitian, nutritionist, acupuncture practitioner, athletic trainer, or any other type of health care provider, the client may seek such services at any time.
2. The theoretical approach that forms the basis of the services provided by your practitioner includes performing massage in a professional manner with the intent to benefit the well being of each client, applying massage and bodywork within the scope of the practitioner's training, utilizing techniques that the practitioner is educated on, and refraining from doing massage on clients with conditions/circumstances under which massage should not be performed. You have the right to complete and current information concerning the practitioner's assessment and recommendation, including the expected duration of the services provided.
3. Supervisor for all practitioners at Tranquility for you:
   Name: Rebecca Gislason; Business Address: 1960 Cliff Lake Road, Ste. 124, Eagan, MN 55122; Phone: (651) 686-5671
   You have the right to file a complaint with be with the practitioner's supervisor, by leaving your name and phone number with the receptionist at the front desk. You will be contacted by the practitioner's supervisor regarding your complaint.
4. If you have a complaint about your treatment it may be directed to the Office of Unlicensed Complementary and Alternative Health Care Practice, Heath Occupations Program, Minnesota Department of Health, P.O. Box 64975, Saint Paul, MN 55164-0975. Phone: (651) 282-5623.
5. Copies of the schedule of charges for services rendered are available at the front desk and apply to all practitioners at Tranquility for you. You have a right to reasonable notice of changes in services or chares, which will be posted at the front desk at least one month prior to any changes. Clients must pay all fees in full at time of services rendered. Cash, check, travelers check, or credit cards including: Visa, MasterCard, & Discover.
6. You may expect courteous treatment and to be free from verbal, physical, or sexual abuse by any practitioner.
7. Your records and transactions with the practitioner are confidential, unless release of these records is authorized in writing by the client, or otherwise mandated by law. You have the right to access your records in accordance with Minnesota Statutes section 144.335.
8. Other services may be available in the community. Whatever information we may have concerning other services, we will be happy to share it with you, should you request it.
9. You have the right to choose freely among available practitioners and to change practitioners after services have begun.
10. You have the right to a coordinated transfer when there will be a change in the provider of services.
11. You have the right to refuse services or treatment, unless otherwise provided by law.
12. You may assert these rights without retaliation.

I have read and received a copy of this Client Bill of Rights.

Signature _____

Date _____