Jessica Gumkowski, CMT – www.massageboulder.com
CONFIDENTIAL INFORMATION HEALTH HISTORY FORM
Welcome. I want your appointment to be as pleasant and comfortable as possible. If at any time you have questions regarding your visit, please let me know.

PATIENT INFORMATION – please print

Name_____ Phone # _____
Address_____
City, State, Zip _____ Email _____
Would you like to join our email list to receive massage specials and news? yes __ no__
Date of Birth __/__/__ Age_____ Sex _____ Height _____ Weight _____
Occupation_____
How did you hear about Massage Boulder _____
Describe any injuries, illnesses and/or surgical operations (include dates)
_____
_____
List Current Medications_____
_____
Who is your regular health care provider/MD? _____
Phone _____
Have you consumed alcohol/drugs or medications in the past 24 hours? __ yes __ no
Explain _____
How many times have you received massage therapy? _____ What types? (see below)
Shiatsu ___ Deep Tissue ___ Other _____

Please indication the amount of your consumption:				
	None	Light	Moderate	Heavy
Salt	____	____	____	____
Sugar	____	____	____	____
Caffeine	____	____	____	____
Tobacco	____	____	____	____
Alcohol	____	____	____	____
Exercise	____	____	____	____
Water	____	____	____	____

HEALTH HISTORY – please check conditions or symptoms that you currently have or have had in the past		
GENERAL:	__ Allergies/Sinus	__ Numbness/Tingling
__ Sciatica	__ Infectious condition	__ Skin condition
__ High blood pressure	__ Inflammation	__ Osteoporosis
__ Seizures/convulsion	__ Dizziness/fainting	__ Varicose veins
__ Bruise easily	__ Arthritis	__ Fibromyalgia
__ Heart condition	__ Chest pain	__ Difficulty breathing
__ Stroke	__ Diabetes	__ Cancer
__ HIV	__ Contact lenses	
NECK:	__ Whiplash	__ Head feels heavy
__ Pain w/ movement	__ Stiff neck	__ Grinding/popping

HEAD:	__ TMJ	__ Grind teeth
__ Splint	__ Headaches/Migraines	__ Light sensitivity
__ Vertigo	__ Ringing in ears	__ Memory loss
SHOULDERS:	__ Bursitis	__ Loss of movement
__ Pain w/ movement		
ARMS & HANDS:	__ Hands cold	__ Loss of grip
__ Pain in wrist		
BACK:	__ Pain when lifting/bending	__ Pain with cough/sneeze
__ Disk problems	__ Other_____	
ABDOMEN:	__ Nausea	__ Incontinence
__ Gas	__ Constipation	__ Diarrhea
__ Tenderness	__ Colitis	__ Diverticulitis
HIPS LEGS & FEET:	__ Leg or foot cramps	__ Swollen ankles
__ Cold feet	__ Ticklish feet	__ Knee surgery
__ Hip replacement		
MALES:	__ Prostrate	__ Hernia
FEMALES:	__ Pregnant/ due date	__ Irregular cycle
__ Endometriosis	__ Other_____	
DO YOU CURRENTLY HAVE?	__ Sunburn	__ Inflammation
__ Severe pain	__ Headache	__ Open cuts/bruises
__ Irritate skin rash/poison ivy	__ Cold/flu	__ infections

Please provide any additional information below.

_____
_____
_____
_____
_____

I understand that I may be denied services if I have consumed drugs or intoxicating substances prior to my appointment and hereby certify compliance with the above stated policy. I understand that my health history and massage sessions are confidential and my records will not be released unless under subpoena or with my written consent. I understand that I may review my file upon request.

_____ _____

Client Signature Date