The Wellness Project
Health History

Date ____/____/_____
Name: _____ **DOB:** __/__/____
Address: _____
City: _____ **State:** _____ **Zip:** _____
Telephone: ( ) _____ **E-mail:** _____
Emergency Contact _____

Your occupation is: _____
Have you had a professional massage before? [ ] Yes [ ] No
If yes, how often? _____

Health History: Please answer the following questions with the best of your knowledge.
Do you have any of the following:

	YES	NO
Joint swelling?		
Edema?		
Osteoporosis?		
Bruising easily?		
Broken bones?		
Circulatory issues?		
Carpal tunnel?		
HIV?		
Skin conditions?		
TMJ?		
Fibromyalgia?		
Myofascial pain syndrome?		
Depression?		
Anxiety?		
Heart disease?		
Blood clots?		
Are you pregnant?		
Migraines?		

	YES	NO
Diabetes?		
If yes, what type?		
Arthritis?		
If yes, what type?		
High blood pressure?		
If yes, what medication?		
If yes, is it controlled?		
Allergies?		
If yes, please list.		
Surgeries?		
If yes, please list.		
Car accidents?		
If yes, please list.		
Cancer?		
If yes, please list type, treatment and dates.		
Muscle pain?		
If yes, please explain.		

Please list any conditions or concerns not covered in the above questions: (use back if necessary)

Please list all medications: (use back if necessary)

Consent To Treatment:
I _____, understand that the massage/bodywork I receive is provided for the basic purpose of relaxation and relief of muscular tension and request and consent to treatment(s) from **KATI DRIBAN, LMT**. I realize that there are no particular therapeutic guarantee's to any treatments I receive and I understand that integrated therapies may be used when receiving any of the body modalities offered and that none of the treatments are intended to take the place of a physician's care.

Client Signature: _____