CLIENT HEALTH HISTORY NAME: _____ DATE: _____

This questionnaire has been designed to help me provide the best professional care and service. The information contained herein will be kept in strict confidence.

Address: _____

Email: _____
Email reminders are sent from Genbook 24 hours before your scheduled appointment. Occasional emails are sent out for specials and discounts. You can request to be removed from the email list at any time.

Phone: (cell/work) _____ (home) _____
Please circle preferred method of communication above.
It is acceptable to call between the hours of _____a.m. and _____p.m.

Date of Birth: _____ Age: _____ Occupation: _____

Referred by: _____ Can I let the referrer know you came in today so they can get the referral discount? YES NO Please initial to give permission _____

Please list your primary health care professional (MD, Chiropractor, Osteopath, NP, etc.)*optional*
_____ Phone: _____

Emergency Contact_____ Phone: _____

Do you wear contacts? _____ Dentures? _____ Are you pregnant? _____ If so, how many months? _____

Are you involved in any other therapy at this time? If so, what, and how often?
_____

Are you currently taking medications? Please list medications, dosages, and what they are treating-
_____
_____

Do you have any current known: Please elaborate if checked.
_____ injuries _____
_____ bruises _____
_____ infections _____
_____ contagious diseases _____
_____ allergies or sensitivities (food, inhalants or smells, detergents, latex, oils, balms, liniments, etc.)
_____

Do you have any of the following?

_____ high blood pressure	_____ heart problems
_____ low blood pressure	_____ kidney problems
_____ any know blood clots	_____ emotional sensitivities
_____ arthritis or bursitis	_____ degenerative discs

Please list any previous injuries (broken bones, severe sprains, whiplash, traumas, etc.) and surgeries-
_____ Date: _____
_____ Date: _____
Continue on a separate sheet, if needed.

Which hand do you write with? L or R

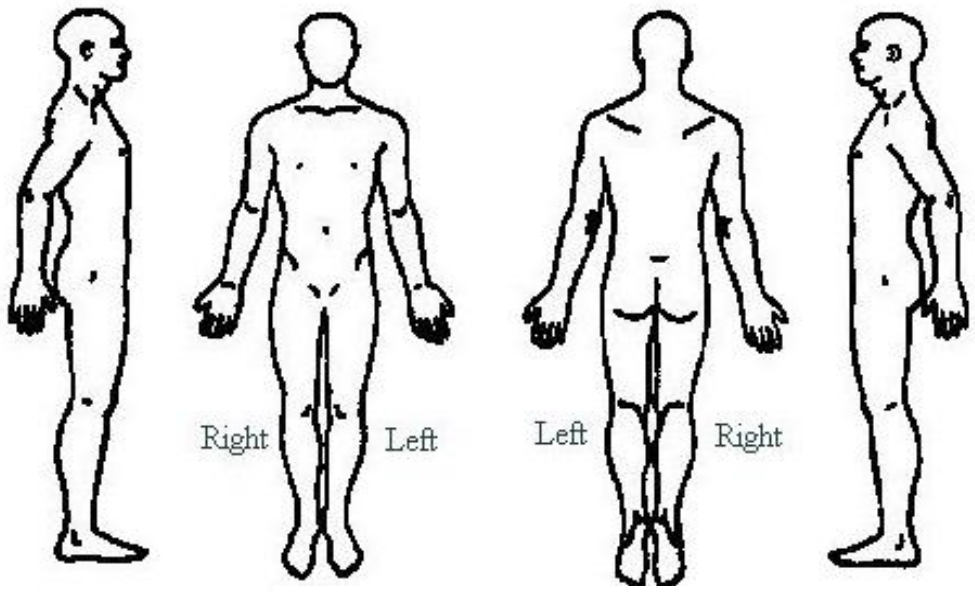
Are there areas you prefer NOT to have worked or pet peeves about previous massages?
_____
_____

Do you feel as if you "hold" stress or tension in any part of your body? (please circle) YES NO
If "yes," is it occasional _____ or frequent _____ ?

Do you experience any of the following?

_____ chronic headaches
_____ chronic backaches
_____ bruxism (clenching, grinding of the teeth)
_____ tightness in the jaw (especially upon waking)

On the diagram below, please circle those areas that best correspond to the places where you feel you hold stress, tension, or those areas where you may be currently experiencing discomfort or pain:



Right Front Back Left

What type(s) of exercise or activities do you do? How often? _____
_____

How would you describe your dietary habits? _____
Approximately how many ounces of water do you drink per day *(not including soda, coffee, or tea)*? _____

What do you currently do to relax, to relieve stress or tension? _____

Have you ever had bodywork/massage done before? If so, for what reason (e.g., relaxation, pain relief, physical therapy, etc.)? _____

When was your last massage? _____

What type of pressure do you usually prefer? (please circle) light medium strong

Is there any other information you feel would be helpful to share with me at this time?
_____
_____

Thank you for your cooperation in completing this form. Please keep me updated on any changes to your medical history. Feel free to use another page if more space is needed for health history.

Mischa Bradford
Massage Therapy

INFORMED CONSENT FORM

I, (client's name) _____, understand that the massage I receive is for the purpose of stress reduction and relief from muscular tension, spasm, or pain, and to increase circulation. If I experience any pain or discomfort (pressure, temperature, etc.), I will immediately inform the therapist, Mischa Bradford, so that the pressure or methods can be adjusted to my comfort level. I do not hold her responsible if I fail to do so. I realize that this massage is therapeutic and non-sexual in nature and any inappropriate behavior on my part will result in an immediate termination of the session and I will be responsible for paying the full session cost.

I understand that massage professionals do not diagnose illness or disease or perform any high-velocity adjustments, nor do they prescribe any medical treatments, and nothing said or done during the session should be construed as such. I acknowledge that massage is not a substitute for medical examination or diagnosis and that I should see a health care provider for those services. Because massage should not be performed under certain circumstances, I agree to fill out my health history honestly and completely, and keep the therapist updated as to any changes in my health profile, and I release her of any liability if I fail to do so. If I am feeling ill, I will postpone my appointment until I am feeling better. For the comfort of the therapist and the clients seen after me, I will refrain from wearing perfume or cologne to my session.

I also understand that the therapist's time is important and missed appointments mean missed income for her. Therefore, if I need to cancel or postpone an appointment, I will give her at least 24 hours' notice or pay a $25 cancellation fee if the appointment time is not filled, to be paid before my next appointment. I realize that if I want my full hands-on time, I should arrive five minutes before my appointment time in order to go over my current bodywork goals, disrobe, and be on the table by my appointment time. Regardless of my arrival time, my appointment will end on time to make sure those following my appointment aren't delayed.

By signing my name below, I acknowledge that I have read and agree to all of the above statements.

Client's signature _____ Date _____

Therapist's signature _____ Date _____

Consent to Treat a Minor (only applicable if the client is under 18)

By my signature I agree to the above statements and I authorize Mischa Bradford to provide therapeutic massage to my child or dependent and I will be present in the room for the entirety of the massage.

Signature of Parent or Guardian _____ Date _____