Tranquil Health Massage & Wellness Center, LLC **Health Information (page 1/2)**
Gayle A. Tanaka, LMT, BCTMB, CNM, MS **970-219-9135**

Client Contact Information

Today's Date: _____

Client Name: _____ Date of Birth: _____ Gender:_____
Address: _____
Phone: _____ Email: _____
Referred by: _____
Emergency contact: _____ Phone: _____
Physician/Health-care Provider name: _____ Phone: _____
*Is this massage/bodywork medically necessary (is it for a medical condition, injury, surgery)? Yes ☐ No ☐
*Do you have a physician referral/prescription? Yes ☐ No ☐
*Are you seeking insurance reimbursement? Yes ☐ No ☐ If yes, please complete the Billing Information form.
*Type of insurance coverage for this claim: Car Collision Worker's Compensation Private Health

Massage Information

*Have you ever received professional massage/bodywork before? Yes ☐ No ☐ *How recently?

_____
*What types of massage/bodywork do you prefer? _____
*What kind of pressure do you prefer? Light Medium Firm
*What are your goals/expected outcomes for receiving massage/bodywork?

_____
_____

*How do you feel today? _____

*List and prioritize your current symptoms/issues (stress, pain, stiffness, numbness/tingling, swelling, etc.):

_____
_____

*Do these symptoms interfere with your activities of daily living (e.g., sleep, exercise, work, childcare)? Yes No Explain:

_____
_____

*List the medications you currently take:

_____
_____

*Are you wearing contacts? Yes ☐ No ☐

*Are you wearing dentures? Yes ☐ No ☐

*Are you wearing a hairpiece? Yes ☐ No ☐

*Are you pregnant? Yes ☐ No ☐

Health History

*Have you had any injuries or surgeries in the past that may influence today's treatment?

_____

*Circle any of the following health conditions that you currently have (If you are unsure, please ask): blood clots, infections, congestive heart failure, contagious diseases, pitted edema
*Please answer honestly, as massage may not be indicated for the above conditions.

Please indicate conditions that you have or have had in the past. Explain in detail, including treatment received:

Current Past Muscle or joint pain _____
Current Past Muscle or joint stiffness _____
Current Past Numbness or tingling _____
Current Past Swelling _____
Current Past Bruise easily _____
Current Past Sensitive to touch/pressure _____
Current Past High/Low blood pressure _____
Current Past Stroke, heart attack _____
Current Past Varicose veins _____
Current Past Shortness of breath, asthma _____
Current Past Cancer _____
Current Past Neurological (e.g. MS, Parkinson's, chronic pain) _____
Current Past Epilepsy, seizures _____
Current Past Headaches, Migraines _____
Current Past Dizziness, ringing in the ears _____
Current Past Digestive conditions (e.g. Crohn's, IBS) _____
Current Past Gas, bloating, constipation _____
Current Past Kidney disease, infection _____
Current Past Arthritis (rheumatoid, osteoarthritis) _____
Current Past Osteoporosis, degenerative spine/disk _____
Current Past Scoliosis _____
Current Past Broken bones _____
Current Past Allergies _____
Current Past Diabetes _____
Current Past Endocrine/thyroid conditions _____
Current Past Depression, anxiety _____
Current Past Memory Loss, confusion, easily overwhelmed _____

Comments_____
_____

***Consent for Treatment: If I experience any pain or discomfort during this session, I will immediately inform the practitioner so that 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 substitute for medical examination, diagnosis, or treatment and that I should see a physician, chiropractor, or other qualified medical specialist for any mental or physical ailment of which I am aware. I understand that massage/bodywork practitioners are not qualified to perform spinal or skeletal adjustments, diagnose, prescribe, or treat any physical or mental illness, and that 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 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. I also understand that any illicit or sexually suggestive remarks or advances made by me will result in immediate termination of the session, and I will be liable for payment of the scheduled appointment. If two sessions are no-shows without at least 4 hours advanced notice, it will require a valid credit card number be kept on file with the therapist to schedule any further appointments and will be charged the regular rate on that card for subsequent missed appointments without at least 4 hours advanced notice. Understanding all of this, I give my consent to receive care. I further release my practitioner from any liability of potentially contracting COVID-19.

Client or Parent/Guardian Signature (in case of a minor):_____ Date: _____