Rachel Ouillette Clinical Bodywork

Confidential Health History

Date	Name			
Address				Telephone
City			ZIP Code	Occupation
Date of Birth	(Circle) M / F	Who referred you?		
Emergency Contact Name & Telephone				
Have you received therapeutic massage or bodywork before? Y / N				
Describe any surgeries or injuries (and dates they occurred)				
Current medications (include over-the-counters and herbals)				

Circle all that apply to your present health

arthritis
athlete's foot
autoimmune disorder
blood clots
cancer
chronic pain
diabetes
fatigue
headaches
heart disease
high or low blood pressure
infection
injury
jaw pain or teeth grinding
limitation of movement
muscle cramping or spasm
muscle or joint pain
numbness or tingling
osteoporosis
pregnancy
scoliosis
skin problems
sleep difficulties
sprains or strains
swelling
tendonitis
tinitis
varicose veins

CONSENT FOR CARE

I give my consent to receive massage therapy. I understand that there is no implied or stated guarantee of success or effectiveness of individual techniques or series of appointments. I acknowledge that massage therapy is not a substitute for medical care, medical examination, or diagnosis. I have stated all medical conditions that I am aware of and will inform my practitioner of any changes in my health status.

Signature ______________________________ Date ________________