

Cumberland Institute of Holistic Therapies Client History

This history is confidential. The information will help to determine if therapeutic massage is indicated and which procedures are appropriate.

Date _____

Client Name _____ Birth Date _____

Street Address _____ Referred By _____

City _____ State _____ Zipcode _____

Home Phone _____ Work Phone _____ ext. _____

Mobile Phone _____ Email Address _____

Employer Name _____ Occupation _____

Please check all that apply:

- | | | |
|--|--|--|
| <input type="checkbox"/> Allergies – list below | <input type="checkbox"/> Dizziness | <input type="checkbox"/> PMS/ Menopause problems |
| <input type="checkbox"/> Arthritis/ Rheumatism | <input type="checkbox"/> Emphysema | <input type="checkbox"/> Poor circulation |
| <input type="checkbox"/> Asthma/ Breathing problems | <input type="checkbox"/> Epilepsy/ Seizures | <input type="checkbox"/> Pregnant/ Trying |
| <input type="checkbox"/> Athlete's foot/ Fungal infections | <input type="checkbox"/> Fibromyalgia | <input type="checkbox"/> Ringing in the Ears |
| <input type="checkbox"/> Back Pain (upper/mid/low) | <input type="checkbox"/> Chronic Headaches | <input type="checkbox"/> Sciatic pain |
| <input type="checkbox"/> Birth Trauma | <input type="checkbox"/> Heart Disease or Problems– list below | <input type="checkbox"/> Sinusitis |
| <input type="checkbox"/> Blood clots/ Phlebitis | <input type="checkbox"/> Hepatitis | <input type="checkbox"/> Skin Rashes |
| <input type="checkbox"/> Broken bones – list below | <input type="checkbox"/> High/Low Blood Pressure | <input type="checkbox"/> Sprains/Dislocations – list |
| <input type="checkbox"/> Bruise easily | <input type="checkbox"/> HIV/AIDS | <input type="checkbox"/> Stiff Neck |
| <input type="checkbox"/> Bursitis | <input type="checkbox"/> Implants – list below | <input type="checkbox"/> Stress/ Anxiety/ Depression |
| <input type="checkbox"/> Cancer/ Tumors – list type/area below | <input type="checkbox"/> Infection/ Inflammation/ Fever | <input type="checkbox"/> Stroke |
| <input type="checkbox"/> Carpal Tunnel Syndrome | <input type="checkbox"/> Kidney/bladder/prostate | <input type="checkbox"/> Surgeries – list below |
| <input type="checkbox"/> Chronic Fatigue | <input type="checkbox"/> Lupus Erythematosus | <input type="checkbox"/> Survivor of abuse/trauma |
| <input type="checkbox"/> Contact Lenses | <input type="checkbox"/> Lymphedema | <input type="checkbox"/> TMJ / Had braces on teeth |
| <input type="checkbox"/> Dermatitis/Eczema/Psoriasis | <input type="checkbox"/> Migraine headaches | <input type="checkbox"/> Ulcer/colitis/diverticulitis |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Neck Pain | <input type="checkbox"/> Varicose veins |
| <input type="checkbox"/> Digestive problems/ Acid Reflux/ IBS | <input type="checkbox"/> Orthopedic pins or plates | <input type="checkbox"/> Whiplash |
| <input type="checkbox"/> Disk problems (slipped, herniated, bulging) | <input type="checkbox"/> Osteoporosis | <input type="checkbox"/> Have received professional massage before today |
| | <input type="checkbox"/> Plantar fasciitis | |

Please explain items checked above _____

Hospitalizations/Surgeries & dates _____

Injuries/accidents & dates _____

Any physical activities that cause you a problem? _____ Servings of Dairy/Day? _____

Trouble Lying in any Position? _____ Exercise Regimen? _____ Days/Week _____

Medications/Supplements (if additional space is necessary, please attach a separate list):

Name _____	Purpose _____
Name _____	Purpose _____
Name _____	Purpose _____
Name _____	Purpose _____

Physician _____ Phone _____

Chiropractor _____ Phone _____

Emergency Contact: _____ Relationship _____ Phone _____

What is your general goal for massage therapy? _____

In a professional massage, your rights as a client include:

- The right to control the amount of pressure applied in any area of your body
- The right to have complete privacy while dressing and undressing
- The right to feel comfortable with the amount of clothing to be removed for the session, and the areas of your body to be touched
- The right to talk or not talk during the session, and to share or not share your internal experiences during the session
- The right to be draped at all times, except for the area being worked, and to feel secure with the draping technique being used
- The right to be listened to carefully, and treated with respect, verbally and non-verbally
- The right to terminate the session at any time

Because massage/bodywork should not be performed under certain medical conditions, I affirm I have stated all my known medical conditions, and answered all questions honestly. I will keep my massage therapist aware of any changes to my medical profile, and understand there shall be no liability of the part of the therapist if I fail to do so. If my medical condition requires it, I understand I may be required to receive clearance from my primary care provider before receiving massage.

Every person brings his or her own history into a massage session. I agree to inform my therapist if touch in any area is uncomfortable for me, needs to be modified to be comfortable, or needs to be avoided for the current session (or any number of sessions). I will also inform my therapist of any changes to my mental or emotional state of being which may influence the choice of modalities to be used or the areas to be worked, for the purpose of enhancing my sense of safety, and my potential holistic benefits from the work.

I will immediately inform the therapist if I experience any pain or discomfort during the session.

I understand that a practitioner's touch and the manner of communication between therapist and client are never intended to be sexual in nature. I agree to immediately inform the therapist if I feel the manner of touch or language feels sexual or inappropriate to me, so the session may be stopped or changed. I understand that any illicit or sexually suggestive remarks or advances made by me, the client, are grounds for immediate termination of the session, and I, the client, will still be liable for payment of the full cost of the scheduled appointment.

I understand that massage therapy is not a substitute for medical examination, diagnosis or treatment. I also understand that the massage/bodywork I receive is for the basic purpose of relaxation, relief of muscular tension, stimulation of the circulatory and lymphatic systems, and craniosacral balance.

I understand that massage therapists are not primary care providers, and any information provided by them is for educational purposes, and should not be taken as medical advice or counseling. If I require medical advice or counseling, I understand I should consult a physician, chiropractor, or other health care practitioner.

I understand my massage will be provided by a student massage therapist as part of his/her training.

I understand that my client information is maintained in compliance with federal privacy laws.

Client Signature _____ Date _____

Therapist Signature _____ Date _____