

Today's date: _____

Confidential Client Information and Health History

First name: _____ M.I. _____ Last name: _____

Address: _____ City: _____ State: _____ Zip: _____

Phone (h) : _____ (w) _____ (cell) _____ Date of birth: _____

Employer: _____ Occupation: _____

Emergency contact: _____ Phone: _____ Relationship: _____

E-mail: _____

How did you hear about us? ____ SHGM Employee/Tamarac Citizen ____ Newspaper/radio/web ____ Expo

Referred by: _____

Are you currently experiencing any of the following conditions?

____ Flu or cold ____ Inflammation ____ Fever ____ Infection ____ Contagious disease

Please check any of the conditions below that currently affect you or that you have experienced in the last two years:

MUSCULOSKELETAL

- Fibromyalgia
- Spasms/cramps
- Sprains/strains
- Osteoporosis
- Gout
- Osteoarthritis/rheumatoid arthritis
- TMJ
- Bursitis
- Plantar fasciitis
- Tendonitis
- Torticollis
- Whiplash syndrome
- Carpal tunnel syndrome
- Sciatica
- Thoracic outlet syndrome
- Headache
- Leg pain
- Arm pain/shoulder pain
- Low back pain
- Mid back pain
- Hip pain
- Other _____

RESPIRATORY

- Pneumonia
- Sinusitis
- Asthma
- Trouble breathing
- Other _____

CIRCULATORY

- Anemia
- Hemophilia
- Hypertension
- Low blood pressure
- Varicose veins
- Heart condition
- Blood clots/phlebitis
- Diabetes
- Bleeding abnormalities
- Other

DIGESTIVE

- Ulcers
- Irritable bowel syndrome
- Colitis
- Gallstones
- Hepatitis
- Crohn's disease
- Diarrhea
- Gas/bloating
- Indigestion
- Other

SKIN

- Infections/rashes
- Acne
- Dermatitis/eczema
- Psoriasis/vitiligo
- Open wound or sore
- Rashes/athletes foot
- Plantar's warts

NERVOUS SYSTEM

- Multiple sclerosis
- Neuritis
- Spinal cord injury
- Stroke
- Trigeminal neuralgia
- Seizure disorders/epilepsy
- Numbness/tingling/twitching
- Other

OTHER

- Insomnia
- Anxiety/panic attacks
- PMS
- Grief process
- Cancer/skin cancer
- Substance abuse
- Chronic fatigue
- HIV/AIDS
- Lupus
- Kidney disease
- Bladder infection
- Edema
- Stress
- Hormonal problems
- Thyroid disease
- Tuberculosis
- Tanning bed use
- Facial injections (Botox/fillers)
- Braces/mouth gear
- Fever blisters/ cold sores

Are you currently under the care of a physician? _____ Physician's Name: _____

Address and Phone: _____

For what are you being treated? _____

Are you receiving any other types of medical or homeopathic treatments? _____ Explain: _____

Please list any (oral or topical) medication (vitamins, herbs or pharmaceutical) taken now or at current intervals (please include an explanation of what medication is used to treat):

Are you pregnant or nursing? _____ How many weeks? _____

Do you have any allergies to fruits, vegetables, metals, medications, cosmetics or other? _____ Please list: _____

Do you have any implants? (pacemakers, pins in bones, etc.) _____

Do you wear contact lenses? _____

To help us serve you better, please circle any service(s) you are interested in now or in the future:

Massage	Pedicure	Facial	Acne treatments
Aromatherapy	Manicure	Waxing	Facial redness/rosacea
Reflexology	Body scrubs/ wraps	Botox/ fillers	Sun damage/brown spots
Hot stone massage	Microdermabrasion	Hair removal	Skin care products
Broken capillaries	Spider veins/leg veins	Wrinkles	Acupuncture
Reiki	Cellulite treatments	Glycolic/salicylic peels	Craniosacral therapy
Permanent makeup	Skin care classes	Glytone	Latisse/eyelash extension
<i>jane iredale</i> makeup	Biotone skincare	Eminence organic skin care	

The above information is accurate and true to the best of my knowledge. I understand that Massage Therapists/Estheticians do not diagnose disease, prescribe medications or manipulate bones. I further understand that massage therapy or esthetic work is not a substitute for medical attention or examination. I take responsibility for alerting my practitioner to any physical, mental or emotional changes that occur with my health. I also understand that cancelled or missed appointments without 24 hours notice (medical emergencies excluded) may be charged in full for the price of the missed session.

If a procedure asks for a follow up conversation which is the best way to contact you? Please Circle One:

Home Phone Cell Phone Email

Signature: _____ Date: _____

Consultation performed by: _____

Physician signature: _____ Date: _____