Ho'ano Massage and Wellness for Women

Name:
First_____Middle_____Last_____

Address_____City, Zip_____

Phone: Daytime_____Home_____Cell_____

Birthdate_____Occupation_____

Referred by:_____Email Address:_____

Emergency Contact:_____Phone:_____

Physician:_____Phone:_____

Massage Information:

First Professional Massage: Yes____No_____: How frequently do you have massage_____

Medical Information:
List accidents/injuries, hospitalizations, and surgeries: when they occurred and treatment received:

Any lingering effects from the above or do you feel you have recovered?

Chronic, ongoing pain? Yes_____No_____Please describe any treatment you receive

Do activities affect the pain? Yes_____No_____, please describe

Are you currently being treated medically or taking prescribed drugs?
Yes_____No_____Please describe_____

Please list all over the counter supplements and/or herbs taken and why:

FOR LYMPHATIC CLIENTS, IF YOU HAVE ANY OF THE FOLLOWING PLEASE MARK A CHECK NEXT TO ANY OF THE FOLLOWING:

---Recent Thrombosis (DVT) ----Acute Inflammation with infection -----Congestive Heart Failure -----Malignant Tumor ---- Hyperthyroidism -----Hypotension -----Bronchial Asthma -----Treated Thrombosis -----Chronic Inflammation ----- Treated Cancer -----TB -----Nevus -----Menstruation -----Pregnancy -----Diabetes Type 2 -----Acute Allergic Reactions

History:

Musculosketal
___Osteoporosis
___Arthritis
___Hypothyroidism
___Fibromyalgia
___Chronic Fatigue
___Gout
___Bursitis
___Plantar Fascitis
___Cysts/Lipomas
___TMJ
___Chronic Headaches
___Tendonitis
___Whiplash
___Strains/Sprains
___Chronic Pain in:
____Neck
____Low Back
____Mid Back
____Upper Back
____Hip
____Shoulder
____Wrist/Hand
____Arm
___On Computer more than 2 hrs a day. No. of hrs.

Respiratory
___Pneumonia
___Asthma
___Breathing Problems
___Sinusitis

Digestive
____Ulcers
____Colitis
____IBS
____Chrone's disease
____Gluten intolerance
____Constipation
____Diarrhea
____Gallstones
____Gas/Bloating
____Chronic Indigestion

Circulatory
____Heart Problems
____Stroke
____Palpitations
____Mitral Valve prolapse
____Anemia
____Hemophilia
____Hypertension
____Low Blood Pressure
____Varicose Veins
____Blood Clots/Phlebitis
____Raynaud's Disease

Skin
____Fungal Infections
____Athlete's Foot
____Impetigo
____Eczema/Dermatitis

Nervous System
____Dizziness
____ALS
____Multiple Sclerosis
____Parkinson's disease
____Bell's Palsy
____Neuritis
____Spinal Cord Injury
____Trigeminal Neuralgia
____Seizures/Epilepsy

Other
____Diabetes
____Pregnancy
____Cancer
____Kidney Disease
____Hepatitis
____HIV/AIDS
____Lupus
____ PostOp:_____
____Cystitis
____High Stress
____Grieving
____Anxiety/Panic
___Bipolar Syndrome
___PMS/Menopause
__Poor Sleep/Insomnia
___Allergies affecting:
___Facial Skin
___Body Skin
___Nose/Sinus

___Other_____	____Psoriasis	___Eyes
	____Easily Irritated Skin	___Stomach/Gut
	____Other _____	___Orthopedic pins

Exercise
Time/day – week: _____ Activities:_____

The above information is accurate. I understand that Massage Therapists do not diagnose disease or prescribe drugs and that they are not a substitute for medical care. I agree to alert my practitioner of any physical or emotional changes as they occur. I also understand that a missed appointment incur charges that I must pay.

That she, is to the best of her knowledge and belief, is in good physical and mental health and has no physical or mental handicap or disability, which would be adversely affected by receiving massage services.

Patron Signature:_____Date:_____

Witness:_____Date:_____