Ocean Sands Wellness Center Health History

Name: ____

Address: ______________________________ City: ______________________

State/Zip: __________ Home# ______________ Cell# ______________ Work# ______________

e-mail: ______________________________

Date of Birth: ___/___/______ ***How did you hear about us?*** ______________________

Briefly describe condition(s) motivating you

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____

When and how did this condition develop?

____

____

____

What makes it better?

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____

What makes it worse?

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____

Please describe your therapeutic goal(s):

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Please check and explain on the reverse any conditions that apply to you:

__inflammation
__joint pain
__osteoporosis
__scoliosis
__arthritis (specify type)
__tendonitis
__skin conditions
__current cellulitis
__current fever
__carpal tunnel syndrome
__plantar fasciitis

__circulatory problems
__swelling/edema
__pregnancy (check if possible)
__blood clots (past or present)
__high/low blood pressure
__heart condition
__pacemaker/defibrillator
__aneurism
__stroke history
__neurological conditions
__headaches

__vertigo
__jaw popping/clicking
__TMJ dysfunction
__bruxism
__ depression
__anxiety
__insomnia
__fibromyalgia
__chronic fatigue syndrome
__general fatigue
__cancer (past or present)
__diabetes (type)

Accidents/Injuries:

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____

____

Surgeries (including dental):

____

____

Current medications: __________________________________

____

____

Daily water consumption: ☐ less than one 1 quart ☐ 1-2 quarts ☐ 2 quarts or more

Do you feel you have a balanced diet? ☐ Yes ☐ No

Do you exercise frequently? ☐ Yes ☐ No If yes, specify how and frequency:

____

• I understand that: massage therapy involves neither diagnosis nor treatment of any condition, and is not a substitute for medical care; techniques will typically include Myofascial Release Therapy; draping will be used at all times; female client's breasts will not be worked on without client's written consent; I itemize here any areas of my body which I wish to be avoided ______________________; if I am uncomfortable for any reason I may request the session be ended, and the session will be ended.

• I understand that any remarks or gestures made by me and interpreted by the massage therapist as sexually suggestive will result in the immediate termination of the session, and I will be liable for payment of the scheduled appointment.

Client: ______________________________ Therapist: ______________________________

Policies of Practice

Payment by cash, check or credit card is due upon completion of each session.

If you must cancel your appointment, please do so more than 24 hours in advance, to ensure availability for other clients. Missed appointments without appropriate notice will be billed the full session amount.

I have read and agree to abide by these policies.

Client: ______________________________