

Client Information

Welcome to the Cortiva Massage Therapy Center. We appreciate your support of our students. Please fill out both sides of this health history form and print clearly. We hope you enjoy your experience.

Name: _____ Date: _____
 Address: _____ Telephone: _____
 City: _____ State: _____ Zip: _____ Gender: Female Male
 Email Address: _____ Date of Birth: _____
 Emergency contact name: _____ Occupation: _____
 Emergency contact information: _____

General Questions

Have you had therapeutic massage before? Yes No If yes, how often? _____
 What are your goals for your massage today? _____

Health Information

Are you currently under the care of a physician? Yes No If yes, please indicate the condition for which you are being treated. _____
 Are you taking any medications? Yes No If yes, please list current medications. _____
 Have you had any surgeries? Yes No If yes, please describe. _____
 Have you had any injuries or accidents? Yes No If yes, please describe. _____
 Are you pregnant or trying to become pregnant? Yes No If you are pregnant, please identify which trimester and if there are any associated conditions. _____

In order to provide you with appropriate and client centered massage, we need an accurate health history. Please check any that apply and explain below.

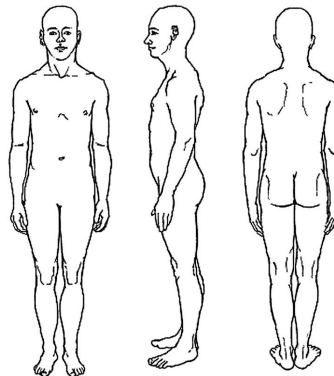
- | | | |
|---|---|---|
| <input type="checkbox"/> Skin conditions | <input type="checkbox"/> Stroke | <input type="checkbox"/> Immune system deficiency |
| <input type="checkbox"/> Blood clots (DVT, phlebitis) | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Arthritis |
| <input type="checkbox"/> High blood pressure | <input type="checkbox"/> Cancer or tumors | <input type="checkbox"/> Osteoporosis |
| <input type="checkbox"/> Congestive heart failure | <input type="checkbox"/> Kidney or urinary problems | <input type="checkbox"/> Fibromyalgia |
| <input type="checkbox"/> Heart attack | <input type="checkbox"/> Respiratory problems | <input type="checkbox"/> Numbness or tingling |
| <input type="checkbox"/> Other cardiovascular disease | <input type="checkbox"/> Infectious disease | <input type="checkbox"/> Other |

Explanation(s): _____

On a scale of 0 (no stress) to 10 (high levels of stress)
Please indicate the general amount of stress in your life. 0 _____ 10

On the figures to the right, please indicate the following areas:

- Where you carry tension (T)
- Areas of discomfort or pain (D)
- Where you hold your stress (S)



I, hereby, acknowledge that all of the above information is correct and that if I have any changes in my health I will let my practitioner know.

The massage/bodywork received today is provided for the purpose of relaxation and relief of muscular tension and students are not qualified to practice on individuals with any acute or complex medical conditions.

Your student therapist is not permitted to receive compensation for massage services.

The Massage Therapy Center reserves the right to refuse massage treatment to any individual for any reason, including inappropriate behavior, illicit or sexually suggestive remarks, abusive or threatening behavior, medical contraindications, repetitive cancellations, tardiness, ethical reasons, or if the individual is, or appears to be, under the influence of alcohol or illegal drugs. Any actions that could reasonably be seen as sexual in nature, including sexual references, offensive language, or similar acts, will not be tolerated. Any Massage Therapy Center staff or faculty member or student has the right to end the session immediately if any of these or other actions occur, and the client will still be responsible for the full payment of the fee.

If the student is not acting in alignment with these expectations, and you feel comfortable speaking directly with the student, please speak to him/her immediately, so that the student may learn from the experience. If you are uncomfortable speaking directly with the student, report any concern to the school's Clinic Manager. You understand and voluntarily accept any risks of which you have been advised associated with your massage, or from any use of the clinic's facilities, and hereby release Cortiva Institute and its employees, practitioners, agents, parent company or other related entity, and insurers from all liability for any injury, including, without limitation, personal, bodily or mental injury, economic loss or any damage to you resulting therefrom. You further release all of the foregoing personnel and entities from all liability arising from any such injury or damage resulting from your failure to disclose any pre-existing condition or failure to inform your practitioner of any discomfort (whether physical or otherwise) or dissatisfaction during the session.

It is my choice to receive massage, and I give my consent to receive treatment.

Signature _____ date _____