LHTA

Laurel Highlands Therapeutic Academy

Original Date:	_____/_____/_____
Dates Revised:	_____/_____/_____

Client History and Information

All questions contained in this questionnaire are strictly confidential and will become part of your personal record.

Name:	☐ M ☐ F	DOB _____/_____/_____
Address:	City/State/Zip:	
Phone:	Cell Phone:	
Email:	*(would you like to be placed on our mailing list? Y N)*	
Current Employer:	Occupation:	
Emergency Contact:	Relationship:	
Emergency Phone:	Cell Phone:	

Marital Status: ☐ **Single** ☐ **Partnered** ☐ **Married** ☐ **Separated** ☐ **Divorced** ☐ **Widowed**

Referred By: Name:

☐ Yellow Pages ☐ Ad (Where:) ☐ Sign ☐ Other:

Are you under the care of a physician now? Name:

Have you ever had a professional massage before? ☐ No ☐ Yes Date of Last:

What are your goals for this massage?

Present Symptoms: What is your major complaint or condition you want to improve?

What activities and products have you used to address this condition? Have they helped?

What activities or products aggravate the condition?

Please list any medications you are currently taking:

A normal hour full body massage consists of the following areas, please circle which areas you would NOT like massaged today:

I WOULD LIKE A NORMAL FULL BODY MASSAGE _____

Head	Chest (male only)	Buttocks region (over sheet)
Face	Abdominal region	Back
Neck	Legs (front and back)	
Arms	Feet	

Therapist initial _____

Health History

Please check the following conditions that apply to you, past and present. Please add your comments to clarify the condition:

Musculo-Skeletal
- ☐ Headaches
- ☐ Joint stiffness/swelling
- ☐ Spasms/Cramps
- ☐ Broken/Fractured Bones
- ☐ Strains/Sprains
- ☐ Back, hip pain
- ☐ Shoulder, neck, arm, hand pain
- ☐ Leg, foot pain
- ☐ Chest, ribs, abdominal pain
- ☐ Problems walking
- ☐ Jaw pain/TMJ
- ☐ Tendonitis
- ☐ Bursitis
- ☐ Arthritis
- ☐ Osteoporosis
- ☐ Scoliosis
- ☐ Bone or joint disease

Circulatory and Respiratory
- ☐ Dizziness
- ☐ Shortness of breath
- ☐ Fainting
- ☐ Cold feet or hands
- ☐ Cold Sweats
- ☐ Swollen Ankles
- ☐ Pressure sores
- ☐ Varicose veins
- ☐ Blood clots
- ☐ Stroke
- ☐ Heart condition
- ☐ Allergies
- ☐ Sinus problems
- ☐ Asthma
- ☐ High blood pressure
- ☐ Low blood pressure
- ☐ Lymphedma
- ☐ Fever

Skin
- ☐ Rashes
- ☐ Allergies
- ☐ Athlete's Foot
- ☐ Warts
- ☐ Moles
- ☐ Acne
- ☐ Cosmetic Surgery

Digestive
- ☐ Nervous Stomach
- ☐ Indigestion
- ☐ Constipation
- ☐ Intestinal gas/bloating
- ☐ Diarrhea
- ☐ Diverticulitis
- ☐ Irritable bowel syndrome
- ☐ Crohn's Disease
- ☐ Colitis
- ☐ Adaptive aids
- ☐ Other: _____

Nervous System
- ☐ Numbness/tingling
- ☐ Twitching of face
- ☐ Fatigue
- ☐ Chronic pain
- ☐ Sleep disorders
- ☐ Ulcers
- ☐ Paralysis
- ☐ Herpes/shingles
- ☐ Cerebral Palsy
- ☐ Epilepsy
- ☐ Chronic Fatigue Syndrome
- ☐ Multiple Sclerosis
- ☐ Muscular Dystrophy
- ☐ Parkinson's disease
- ☐ Spinal cord injury

Reproductive System
- ☐ Pregnancy: Due date: _____

- ☐ PMS
- ☐ Menopause
- ☐ Pelvic Inflammatory Disease
- ☐ Endometriosis
- ☐ Hysterectomy
- ☐ Fertility concerns
- ☐ Prostate problems

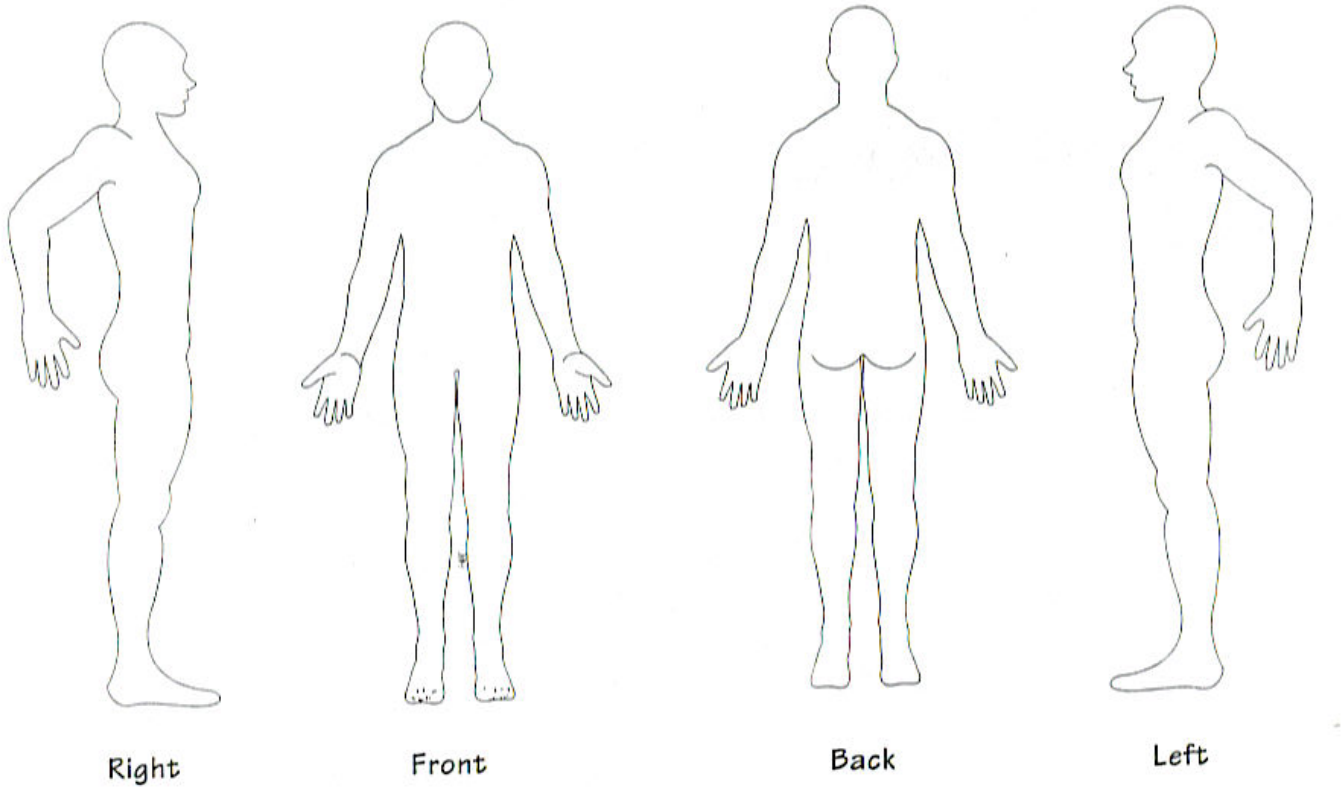
- ☐ Loss of appetite
- ☐ Forgetfulness
- ☐ Confusion
- ☐ Depression
- ☐ Thyroid deficiency
- ☐ Drug use
- ☐ Alcohol use
- ☐ Nicotine use
- ☐ Caffeine use
- ☐ Hearing impaired
- ☐ Visually impaired
- ☐ Burning upon urination
- ☐ Bladder infection
- ☐ Eating disorder
- ☐ Diabetes
- ☐ Fibromyalgia
- ☐ Post/Polio Syndrome
- ☐ Cancer
- ☐ Infectious disease: (Please list) _____
- ☐ Other congenital or acquired disabilities (Please list) _____ _____
- ☐ If you need mobility assistance – please list your height and weight:_____

Please identify current problem areas in your body by drawing the appropriate symbols on the diagrams below:

KEYS:

Therapist initial _____

O	Circle areas where pain exists.
X	Put and "X" over tight areas.



Comments:

By my signature I attest that this is my full and complete medical history to the best of my knowledge. I authorize Laurel Highlands Therapeutic Academy to assess my condition and to carry out the plan of care determined by the Massage Therapist in agreement with my physician. Client hereby releases and discharges Therapist from any and all claims, liabilities, damages, actions, or causes of action arising from the therapy received hereunder, including, without limitation, any damages arising from acts of active or passive negligence on the part of the Therapist, to the fullest extent allowed by law.

Client Signature: _____ Date Signed: _____

Witness (Therapist): _____

Therapist initial _____