Tania Palermo, LMT – Studio on Main
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Manchester, CT 06042
860.306.0067

**Please note – this is a perfume free environment. Please do not wear any perfumes to your appointment.**

## Client Health History Form

[Please print, complete and bring with you the day of your **first** appointment]

Date: _____ Referred by: _____

Name:_____ Cell Phone: _____**

**Is it OK to send you text message reminders for your scheduled appointments? Yes_____ No_____

Street Address: _____ Home Phone:_____

Town:_____ Work Phone:_____

State, Zip:_____ Date of Birth:_____/_____/_____

Email:_____ [for appointment communication]

*If you would like to receive email regarding massage specials and other events indicate: Yes_____ No_____*

Occupation:_____ Exercise/Sports:_____

Smoker: Yes____ No_____ Have you ever received a Therapeutic Massage? Yes_____ No_____

Was it intended for stress relief & relaxation?_____ Pain relief?_____ Both? _____

Reason for today's visit:_____

List any accidents, fractures, and surgeries in the past 5 years: _____

_____

List any accidents, fractures, and surgeries beyond 5 years ago:_____

Describe any current or ongoing muscular-skeletal pain or stiffness: _____

_____

Please list current medications you are taking:_____

Allergies or sensitivity to oils, lotions, scents? No____ Yes [please list]_____

Are you pregnant?_____ If so, how far along:_____

**Existing Conditions:** Please check all that apply now and place a "P" for any conditions experienced in the past.

Varicose Veins_____ Blood Clots_____ Swollen Extremities_____ Numbness/Tingling_____ Herniated Disc_____
Sciatica_____ Scoliosis_____ Osteoporosis_____ Muscle Tightness_____ Infectious Disease_____ Depression_____
Bowel Irregularities_____ Muscle Injuries_____ Joint Injuries_____ Bone Injuries_____ TMJ/Jaw Pain_____
Headaches_____ Migraines_____ Neck Pain_____ Dizziness/Fainting_____ Loss of Balance_____
Inner Ear Problem_____ Allergies_____ Sinus Pain/Infection_____ Asthma_____ Thyroid Imbalances_____
Hypoglycemia_____ Diabetes_____ Cancer/Tumors_____ Respiratory Problems_____ Seizures_____
Immune Deficiency_____ Skin Sensitivity_____ Low Blood Pressure_____ High Blood Pressure_____
Easy Bruising_____ Sleep Irregularity_____ Hepatitis_____ Herpes_____ Chronic Fatigue_____ Chronic Stress_____
Fibromyalgia_____

Other medical conditions not listed:_____

Please explain any areas noted above if you are currently seeing a doctor for that condition:

_____

The information shared on this form and in session is treated with confidentiality. Please give feedback at any time during or after the massage. This communication between you and me during the massage will facilitate a more productive outcome from the session for you.

I, the client, understand that the work done during this massage does not constitute medical treatment and that the massage therapist is not a physician. The session is a form of health and wellness maintenance utilizing the techniques of massage and holistic healing. I, the client, take responsibility for alerting the therapist to any conditions that might affect this work. It is recommended that I, the client, see a physician for any ailments I might have. Any suggestions made by the massage therapist are recommendations, not prescriptions. I understand and agree to the above conditions.

Please note: 24 hours is expected and appreciated in the event of a cancellation. Emergencies are accepted for the first cancellation without 24 hours notice. Otherwise, regular session fee is due.
Payment for massage is required **at time of appointment**. Cash and Credit Card are acceptable forms of payment.
All Credit Card payments will incur an additional 2.5% processing fee.

Client Signature:_____

Date:_____