

Awakening Hands:

Best Miami Massage brought to your doorsteps...



Medical History Form

Name: _____ Date: _____
 Address: _____ Phone: _____
 City/State: _____ Zip: _____ Cell: _____
 DOB: _____ E-mail: _____ Referred by: _____
 Emergency Contact/Relationship: _____ Phone: _____
 Last time you had a massage? _____

Please check off any of the following conditions which apply to you. Now (X) -or- Past (0):

<input type="checkbox"/>	High Blood Pressure	<input type="checkbox"/>	Blood Clots	<input type="checkbox"/>	Muscle Sprain/Strain	<input type="checkbox"/>	Bruise Easy
<input type="checkbox"/>	Low Back Pain	<input type="checkbox"/>	Heart Attack	<input type="checkbox"/>	Stroke	<input type="checkbox"/>	Seizures
<input type="checkbox"/>	Varicose Veins	<input type="checkbox"/>	Headaches	<input type="checkbox"/>	Skin Infections	<input type="checkbox"/>	Osteoporosis
<input type="checkbox"/>	Hypo/Hyperglycemia	<input type="checkbox"/>	Pregnant	<input type="checkbox"/>	Diabetes	<input type="checkbox"/>	Circulatory Problems
<input type="checkbox"/>	Allergies	<input type="checkbox"/>	Blood Thinners	<input type="checkbox"/>	Bursitis	<input type="checkbox"/>	Fibromyalgia
<input type="checkbox"/>	Vertigo	<input type="checkbox"/>	Depression	<input type="checkbox"/>	Numbness Extremities	<input type="checkbox"/>	Hypersensitivity of Skin
<input type="checkbox"/>	Others	<input type="checkbox"/>		<input type="checkbox"/>		<input type="checkbox"/>	

Please list and explain other conditions/symptoms you are or have experienced:

Please list any medications you are taking:

Have you had any surgeries, chronic illness, or traumatic accidents? (if yes, please explain):

Present symptoms/Major concerns:

How long have you had this condition?: _____ **Quality of pain?**

Dull Sharp Burning

What was the initial cause?:

Are you currently, or have you at any time within the last 12 months been under the care of a physician? (if yes, please explain):

List any other symptoms or health concerns:

Do you consume: Coffee Tea Soft Drink Alcohol **Do you smoke?**

Informed Consent and Massage Policies

I understand that the massage I will be receiving here is for the purpose of stress reduction, relief from muscular tension or spasm and is non-sexual whatsoever. I understand that the massage therapist does not prescribe medical treatment or pharmaceuticals, nor do they perform spinal manipulations. I understand that massage is not a substitute for medical treatment or diagnoses and that it is recommended that I see a physician for any physical ailments that I may have.

I acknowledge that the information I have provided on this form is correct and current to the best of my knowledge. I understand that it is my responsibility to inform the massage therapist of any changes to this information and agree that there shall be no liability on the practitioners part should I fail to do so. I understand that if I experience any unusual discomfort and/or pain during my massage session it is my responsibility to inform the massage therapist so that they can adjust the pressure or technique being used.

All written records and massage sessions are kept strictly confidential and will not be shared with any outside establishment, individuals, organizations, or medical facilities without explicit written consent from the client or the client's legal guardian. Unless legally required by local, state, or federal subpoena, summons, or court order.

If I miss a scheduled appointment without giving 24 hours notice, I agree to pay for the missed appointment.

By signing this release, I hereby waive Awakening Hands LLC, its staff and massage therapists from all liability past, present and future relating to massage and bodywork.

Signature: _____ Date: _____

Place an "X" over problem areas.

