SPACIBO

6 HEALTH HISTORY

Please check any conditions or symptoms you currently have or have had in the past:

☐ Anemia	☐ Cancer	☐ Hernia	☐ Pacemaker	☐ Stroke
☐ Anorexia	☐ Chemical Dependency	☐ Herniated Disk	☐ Parkinson's Disease	☐ Tendonitis
☐ Appendicitis	☐ Diabetes	☐ Herpes	☐ Pinched Nerve	☐ Thyroid Problems
☐ Arthritis	☐ Emphysema	☐ High Blood Pressure	☐ Pneumonia	☐ Tuberculosis
☐ Asthma	☐ Epilepsy	☐ Jaw Pain/TMJ	☐ Polio	☐ Tumors/Growths
☐ Blood Clots	☐ Fractures	☐ Lymphedema	☐ Prosthesis	☐ Ulcers
☐ Breathing Difficulty	☐ Glaucoma	☐ Migraine Headaches	☐ Psychiatric Care	☐ Varicose Veins
☐ Bursitis	☐ Head Injuries	☐ Mononucleosis	☐ Rheumatoid Arthritis	☐ Whiplash
☐ Bronchitis	☐ Heart Disease	☐ Multiple Sclerosis	☐ Rheumatic Fever	☐ Other: ______________
☐ Bulimia	☐ Hepatitis	☐ Osteoporosis	☐ Sinus Problems	

MEDICATIONS		ALLERGIES	VITAMINS / HERBS / MINERALS
Medication	*Taking For*		

EXERCISE	WORK ACTIVITY	LIFESTYLE
☐ None ☐ Daily ☐ Moderate ☐ Heavy	☐ Sitting ☐ Light Labor	Smoking: _______ packs/day
	☐ Standing ☐ Heavy Labor	Alcohol: _______ drinks/wk
		☐ Coffee/Caffeine
		☐ High Stress Level

Are you pregnant? ☐ Yes ☐ No Due Date: ____________

Additional medical conditions, surgeries, accidents, injuries: ____________

7 AUTHORIZATION

I certify that the above information is correct to the best of my knowledge. I will not hold my massage therapist or any members of his/her staff responsible for any errors or omissions that I may have made in the completion of this form. I have disclosed all medical conditions that I am aware of and will inform my massage therapist of any changes in my health status. I hereby request the aforementioned health care providers release to you a report of my diagnosis, treatment, prognosis and recommendations, and other information pertinent to your treatment of me. I understand that massage therapy services are designed to be a health aid and are in no way a substitute for a doctor's care. Information exchanged during massage sessions is educational in nature and is to be used at my own discretion.

CANCELLATION POLICY:
We require a minimum of 24 hours notice to cancel or reschedule an appointment. Missed appointments or cancellations made with less than 24 hours notice will be **charged the FULL session fee.**

Date: ____________ Signature: ____________