

Boulder College of Massage Therapy ~ Teaching Clinic
CONFIDENTIAL HEALTH HISTORY FORM

Welcome. We want your appointment to be as pleasant and comfortable as possible. If you have questions, please let us know.

First Name: _____ M.I. _____ Last Name: _____

Address: _____ City: _____ ST: _____ Zip: _____

Phone (h): _____ (c): _____ (w): _____

Birth Date: ____/____/____ Occupation: _____

Emergency Contact: _____ Phone: _____ Relationship: _____

Would you like to be on our email list to receive coupons and special offers? Yes ___ No ___

Email Address: _____

Do you wear contacts? _____ Dentures? _____ Hearing Aid? _____ Do you exercise? _____

How much water do you drink in a day? _____ Do you consider yourself stressed? _____

When was your last massage? _____ How frequently do you get a massage? _____

Describe any surgeries, hospitalizations, accidents or injuries you have had:

Less than 5 years ago: _____

More than 5 years ago: _____

Do you have any chronic, ongoing pain that you deal with on a regular basis? Yes ___ No ___

Please explain: _____

Describe what activities cause this pain and/or make it worse: _____

Please list all current medications: _____

Do you have allergic reactions to any oils, lotions or other substances applied to your skin? Yes ___ No ___

If yes, please identify and explain _____

Check any or all that apply to your present health:

- | | | |
|--|--|--|
| <input type="checkbox"/> Headaches | <input type="checkbox"/> Numbness/tingling | <input type="checkbox"/> Varicose veins |
| <input type="checkbox"/> Vision problems | <input type="checkbox"/> Blood clots | <input type="checkbox"/> High / low blood pressure |
| <input type="checkbox"/> Sinus problems | <input type="checkbox"/> Scoliosis | <input type="checkbox"/> Muscle or joint pain |
| <input type="checkbox"/> Jaw pain/teeth grinding | <input type="checkbox"/> Arthritis | <input type="checkbox"/> Diabetes |
| <input type="checkbox"/> Fatigue | <input type="checkbox"/> Tendonitis | <input type="checkbox"/> Cancer / tumors |
| <input type="checkbox"/> Depression | <input type="checkbox"/> Lymphatic condition | <input type="checkbox"/> Infectious disease |
| <input type="checkbox"/> Sleep difficulties | <input type="checkbox"/> Osteoporosis | <input type="checkbox"/> HIV / Aids |

Women: Pregnant? No ___ Yes ___ Due Date: _____ Men: Prostate problems? No ___ Yes ___

I understand that I will be receiving a massage from a student. I understand that an instructor may enter the room during my massage to observe the student and may demonstrate hands-on techniques on me. I understand that I may be denied services in the BCMT clinic if I behave inappropriately during the session, or have consumed drugs or intoxicating substances prior to my appointment, and hereby certify compliance with the stated policy.

Signature

Date