# Mujō Wellness Health History Information Form

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## Client Contact Information:

Client Name: _____ Date: _____
Date of Birth: _____ Gender: _____
Address: _____
Phone: _____Email:_____

Referred by:_____
Emergency Contact: _____ Phone: _____
Physician/Health-care Provider name: _____ Phone: _____

## Massage Information:

Have you ever received professional massage/bodywork before? Yes ☐ No ☐

What kind of pressure do you prefer? Light ☐ Medium ☐ Firm ☐

Do you like heat on the table? Yes ☐ No ☐

## Health History:

List and prioritize your current symptoms/issues (stress, pain, stiffness, swelling, numbness/tingling, etc.):

_____
_____
_____

Do you have any injuries or surgeries currently or in the past that may influence today's treatment?

_____
_____
_____

List the medications/supplements you currently take:

_____
_____
_____

Are you pregnant? Yes ☐ No ☐ If yes, how many weeks? _____

Please check any of the following health conditions that you currently have:

Blood Clots □ Congestive Heart Failure □ Pitted edema □ Infections □ Contagious Diseases □ Warts □ Ringworm □ Fungal Infections □

If checked, describe/indicate location: _____

Additional Comments:

_____

_____

_____

## Consent for Treatment:

If I experience any pain or discomfort during this session, I will immediately inform the practitioner so that the pressure and/or strokes may be adjusted to my level of comfort. I further understand that massage/bodywork should not be construed as a substitute for medical examination, diagnosis, or treatment and that I should see a physician, chiropractor, or other qualified medical specialist for any mental or physical ailment of which I am aware.

I understand that massage/bodywork practitioners are not qualified to perform spinal or skeletal adjustments, diagnose, prescribe, or treat any physical or mental illness, and that nothing said in the course of the session given should be construed as such.

Because massage/bodywork should not be performed under certain medical conditions, I affirm that I have stated all my known medical conditions and answered all questions honestly. I agree to keep the practitioner updated as to any changes in my medical profile and understand that there shall be no liability on the practitioner's part should I fail to do so.

I understand that any illicit or sexually suggestive remarks or advances made by me will result in immediate termination of the session, and I will be liable for payment of the scheduled appointment.

I am aware that cancelling an appointment with less than 24 hours notice will warrant a $30 late cancellation fee. If I forget or consciously chooses to forgo my appointment for any reason, it will be considered a "no-show." I am aware I will be charged in full for any "missed" appointment. I agree that both late cancellations and no-show fees will be paid within 24 hours of the appointment.

Understanding all of this, I give my consent to receive care.

Client Signature: _____Date: _____

Parent or Guardian Signature (in case of a minor):_____ Date:_____

Massage Therapist Signature: _____Date: _____