

# Mujō Wellness Health History Information Form

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## Client Contact Information:

Client Name: \_\_\_\_\_ Date: \_\_\_\_\_

Date of Birth: \_\_\_\_\_ Gender: \_\_\_\_\_

Address: \_\_\_\_\_

Phone: \_\_\_\_\_ Email: \_\_\_\_\_

Occupation: \_\_\_\_\_ 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.):

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

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List the medications/supplements you currently take:

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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:

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Additional Comments: \_\_\_\_\_

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**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 if I cancel **the day before my appointment**, Mujo Wellness charges **50%**. If I cancel **the day of my appointment or don't show** for my scheduled appointment time, I will be charged **100%**. I agree that both cancellation 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: \_\_\_\_\_