Cumberland Institute of Holistic Therapies Client History

This history is confidential. The information will help determine if therapeutic massage is indicated and which procedures are appropriate.

Date_____________________________

Client Name______________________________________ Birth Date_______________________

Street Address ___________________________________Referred By________________________

City___________________________________ State______________ Zip code ________________

Home Phone __________________________Work Phone____
Mobile Phone_________________________________ Email Address______________________________
Employer Name____________________________ Occupation __________________________________

Please check all that apply:

___ Auto-immune disorders
___ Arthritis/ Rheumatism
___ Breathing problems (asthma, COPD)
___ Back Pain (upper/mid/low)
___ Birth Trauma
___ Blood clots
___ Bruise easily
___ Cancers/ Tumors-list type/area below
___ Circulatory/Heart Problems
___ Cosmetic Procedures (Botox, fillers)
___ Diabetes
___ Digestive / GI problems
___ Disc problems (slipped, herniated/bulging)
___ Dizziness
___ Hepatitis
___ High /Low Blood Pressure
___HIV/ AIDS
___ Lymphedema
___Migraines/Chronic Headaches
___Neck pain/stiffness
___ Neurological issues (seizures, stroke, concussion)
___Osteoporosis
___ Pregnant/Trying
___ Stress/Anxiety/Depression
___ Survivor of abuse/ trauma
___Have received professional massage before
___ TMJ/Had braces
___ Varicose Vein
___ Whiplash
___Seasonal allergies
___ Allergies, list below
___ Skin Disorders

Have you had any illness, fever or vaccines in the last 72 hrs? No Yes
Medical Diagnosis not listed above:____
____
Please explain items checked above____
____
Hospitalizations/Surgeries & dates
____
____
Injuries, broken bones, sprains, strains, accidents & dates______________________________________
____
Any physical activities that cause you a problem? ______________________Servings of Dairy/Day? ________
Trouble Lying in any Position? ____________________Exercise Regimen?_______________________________

Medications/Supplements (if additional space is necessary, please attach a separate list):

Name___________________________________ Purpose____
Name____________________________________Purpose____
Name____________________________________ Purpose____
Name____________________________________Purpose____

Physician____________________________________ Phone ______________________________________
Chiropractor_________________________________ Phone______________________________________
Emergency Contact ___________________________ Relationship ___________________ Phone_____________

What is your general goal for massage therapy?
____

In a professional massage, your rights as a client include:

- The right to control the amount of pressure applied in any area of your body
- The right to have complete privacy while dressing and undressing
- The right to feel comfortable with the amount of clothing to be removed for the session, and the areas of your body to be touched
- The right to talk or not talk during the session, and to share or not share your internal experiences during the session
- The right to be draped at all times, except for the area being worked, and to feel secure with the draping technique being used
- The right to be listened to carefully, and treated with respect, verbally and non-verbally
- The right to terminate the session at any time

Because massage/bodywork should not be performed under certain medical conditions, I affirm I have stated all my known medical conditions and answered all questions honestly. I will keep my massage therapist aware of any changes to my medical profile and understand there shall be no liability of the part of the therapist if I fail to do so. If my medical condition requires it, I understand I may be required to receive clearance from my primary care provider before receiving massage.

Every person brings his or her own history into a massage session. I agree to inform my therapist if touch in any area is uncomfortable for me, needs to be modified to be comfortable, or needs to be avoided for the current session (or any number of sessions). I will also inform my therapist of any changes to my mental or emotional state of being which may influence the choice of modalities to be used or the areas to be worked, for the purpose of enhancing my sense of safety, and my potential holistic benefits from the work.

I will immediately inform the therapist if I experience any pain or discomfort during the session.

I understand that a practitioner's touch and the manner of communication between therapist and client are never intended to be sexual in nature. I agree to immediately inform the therapist if I feel the manner of touch or language feels sexual or inappropriate to me, so the session may be stopped or changed. I understand that any illicit or sexually suggestive remarks or advances made by me, the client, are grounds for immediate termination of the session, and I, the client, will still be liable for payment of the full cost of the scheduled appointment.

I understand that massage therapy is not a substitute for medical examination, diagnosis or treatment. I also understand that the massage/bodywork I receive is for the basic purpose of relaxation, relief of muscular tension, stimulation of the circulatory and lymphatic systems, and craniosacral balance.

I understand that massage therapists are not primary care providers, and any information provided by them is for educational purposes and should not be taken as medical advice or counseling. If I require medical advice or counseling, I understand I should consult a physician, chiropractor, or other health care practitioner.

I understand my massage will be provided by a student massage therapist as part of his/her training.

I understand that my client information is maintained in compliance with federal privacy laws.

I understand massage involves close physical proximity over an extended period of time and there may be an elevated risk of disease transmission, including COVID-19. By signing this form, I acknowledge I am aware of risks involved and consent to treatment.

Client Signature_______________________________ Date_____________________________________

Therapist Signature___________________________________Date________________________________