



# NATURAL HEALTH CARE CENTER

Promoting Total Health Awareness

Cory M. Blust, MT  
672 Miami St., Suite B  
Tiffin, OH 44883

(419) 447-1888 (Office) (419) 447-6260 (Fax)  
info@nhcctiffin.com (E-mail)  
[www.nhcctiffin.com](http://www.nhcctiffin.com) (Website)

## Client Medical History - Massage

Name \_\_\_\_\_ Date \_\_\_\_\_

Reason for Visit \_\_\_\_\_ Occupation \_\_\_\_\_

Referred By \_\_\_\_\_ Sex \_\_\_\_\_ Birthdate \_\_\_\_\_

Address \_\_\_\_\_ City/State/Zip \_\_\_\_\_

Home Phone \_\_\_\_\_ Work Phone \_\_\_\_\_ Cell Phone \_\_\_\_\_

Family Physician \_\_\_\_\_

Present Medications \_\_\_\_\_

Major Operations and Dates \_\_\_\_\_

Allergies \_\_\_\_\_

Rate your degree of body flexibility:  Excellent  Good  Fair  Poor

Do you take a daily vitamin/mineral supplement?  Yes  No

Do you experience shortness of breath?  Yes  No

Do you smoke?  Yes  No

If yes, how much? \_\_\_\_\_

- |  |  |   |
|--|--|---|
| <input type="checkbox"/> Cysts/Tumors/Cancer | <input type="checkbox"/> Tuberculosis    | <input type="checkbox"/> Low Blood Pressure |
| <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Heart Problems  | <input type="checkbox"/> Kidney Problems    |
| <input type="checkbox"/> Bladder Problems    | <input type="checkbox"/> Cold Hands/Feet | <input type="checkbox"/> Bruise Easily      |
| <input type="checkbox"/> Constipation        | <input type="checkbox"/> Water Retention | <input type="checkbox"/> High Fever         |
| <input type="checkbox"/> Back Problems       | <input type="checkbox"/> Ulcers          | <input type="checkbox"/> Anemia             |
| <input type="checkbox"/> Strokes             | <input type="checkbox"/> Diarrhea        | <input type="checkbox"/> Diabetes           |
| <input type="checkbox"/> Indigestion         |  |   |

Indicate current problem areas:

- |              |   |  |  |
|--------------|---|--|--|
| Head/Neck    | <input type="checkbox"/> Frequent Headaches   | <input type="checkbox"/> Neck Pains/Tightness  | <input type="checkbox"/> Neck Lumps/Swelling |
| Digestive    | <input type="checkbox"/> Bloating Stomach     | <input type="checkbox"/> Constipation          | <input type="checkbox"/> Loose Bowels        |
| Skin         | <input type="checkbox"/> Bruise Easily        | <input type="checkbox"/> Open Cuts/Sores       | <input type="checkbox"/> Hypersensitive      |
| Neurological | <input type="checkbox"/> Difficulty Relaxing  | <input type="checkbox"/> Sleeping Difficulties |  |
| Eyes         | <input type="checkbox"/> Wears Glasses        | <input type="checkbox"/> Wears Contacts        |  |
| Respiratory  | <input type="checkbox"/> Breathing Difficulty |  |  |

- Cardiovascular
- High Blood Pressure  Low Blood Pressure  Swollen Feet/Ankles  Leg Cramps

Musculoskeletal

Aching Muscles

Shoulder Pain

Aching Joints

Painful Feet

Lower Back Pain

Carpal Tunnel Syndrome

Tennis Elbow

Indicate diagnosed illnesses (not currently being treated) with a "D" and Indicate illnesses which you are currently undergoing treatment for with a "T".

\_\_\_ Arthritis/Rheumatism

\_\_\_ Disease of Bones/Joints

\_\_\_ Neuritis/Neuralgia

\_\_\_ Bursitis

\_\_\_ AIDS\*

\_\_\_ Ulcers

\_\_\_ Kidney/Bladder Ailment

\_\_\_ Colitis/Bowel Disorder

\_\_\_ Diabetes

\_\_\_ Sciatica

\_\_\_ CVA/Stroke

\_\_\_ Tuberculosis

\_\_\_ Hypertension

\_\_\_ HIV+

\_\_\_ Epilepsy

\_\_\_ Broken Bones(s) - Where?/When? \_\_\_\_\_

\_\_\_ Sprain/Dislocation - Where?/When? \_\_\_\_\_

\_\_\_ Cancer/Tumors - Where?/When? \_\_\_\_\_

\_\_\_ Heart Disease - Where?/When? \_\_\_\_\_

\* Note AIDS clients, please note specific diagnoses and/ or medications which can affect method of therapy:

\_\_\_\_\_  
\_\_\_\_\_

For Women Only:

Pregnant

Lump/Pain in Breasts

Cramps

Date of Last Period \_\_\_\_\_

Client Agreement

I understand that the massage/bodywork I receive is provided for the basic purpose of relaxation, stress reduction, relief of muscular tension or therapeutic applications. 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 of medical examination, diagnosis or treatment, and that I should see a physician, chiropractor or other qualified medical specialist for any mental or physical ailment that I am aware of.

I understand that massage therapists/bodyworkers 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(s) given should be construed as such.

Because massage/bodywork is contraindicated (should not be done) under certain medical conditions, I affirm I have started 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 forget to do so.

It is also understood 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 the "full" scheduled appointment.

Client Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Practitioner: \_\_\_\_\_ Date: \_\_\_\_\_