Health History Form

Sex:
Male ☐ - Female ☐
Other: _____

Name _____ Date _____

Address _____City_____State_____ Zip _____

Home Phone (_____)_____ Cell Phone (_____)_____ Work Phone (_____)_____

Age_____ Height_____ Weight _____ DOB _____ Occupation_____

Email_____ I would like to receive occasional updates about the clinic **Yes/No**

Emergency Contact Name/Number _____

How did you hear about our clinic? _____

Are you currently being treated by a physician? ☐Yes ☐No For what purpose? _____

List current **medications & purpose** _____

_____

List medications which may affect blood clotting _____

List any **surgeries** & **dates** that we should be aware of _____

_____

List joint replacements, pins, bars, implants, etc. _____

Are you pregnant? ☐Yes ☐No How many weeks _____ or *trying* to become pregnant? ☐Yes ☐No

Are you allergic to any ***nut*** oils? ☐Yes ☐No If yes, please list_____ Are you allergic to ***latex***? ☐Yes ☐No

Have you had any lymph nodes removed? ☐Yes ☐No Year of removal, how many removed & area of removal _____

_____

Please check any ***diagnosed medical conditions & any*** **current or chronic** conditions you may have:

- ☐ arthritis
- ☐ asthma
- ☐ blood clots
- ☐ bruise easily
- ☐ cancer – ***If yes, see below*** *
- ☐ chest pain
- ☐ chronic cough
- ☐ depression
- ☐ diabetes
- ☐ disc problems
- ☐ edema/swelling/inflammation
- ☐ epilepsy
- ☐ fatigue
- ☐ fibromyalgia
- ☐ fractures
- ☐ infection(s)
- ☐ headaches
- ☐ heart condition
- ☐ high blood pressure
- ☐ kidney condition
- ☐ limited movement
- ☐ liver condition
- ☐ low blood pressure
- ☐ neck pain
- ☐ osteoporosis
- ☐ numbness
- ☐ phlebitis
- ☐ poor circulation
- ☐ PTSD
- ☐ sciatica
- ☐ sinus problems
- ☐ skin disorders
- ☐ swollen joints/joint pain
- ☐ varicose veins
- ☐ other _____
- ☐ other _____
- ☐ other _____

* If you checked yes to cancer, when was your last treatment _____? Do you still experience any side effects? YES OR NO

Please list any past conditions &/or motor vehicle accidents that we should be aware of: _____

_____

I understand the above information is strictly confidential and is used to help the massage therapist determine any indications or contraindications for massage. I understand that I am **receiving a student massage for the purpose of the student massage therapist's training** and I release the Onondaga School of Therapeutic Massage, including but not limited to, its students, faculty, staff and administration, from any liability that may occur as a result of this session.

Signed: _____ Date: _____

ONONDAGA SCHOOL
OF THERAPEUTIC MASSAGE

To Our Valued Clients:

We are pleased to welcome you to our Student Clinic. The Student Clinic is a teaching clinic and a requirement for graduation. The clinic experience allows students to practice on a diverse population in preparation for entry into the profession of massage therapy. The following are the policies and guidelines governing the Student Clinic.
The staff and students here at OSTM thank you for your continued patronage and support as you directly contribute to the wonderful success of our students. We look forward to seeing you in the future!

Best Regards ~ The Clinic Staff

By signing below, I understand and agree to the following:

OSTM offers basic full-body Swedish massages in 50-minute increments. **Student Clinic is an extension of OSTMs classroom environment, therefore, it is run for the benefit of our students' learning, which allows OSTM to provide our clients with a discounted rate on treatments.** Deep tissue therapies, specific muscle treatments and other modalities of massage are not standard clinic practice. I understand that the clinic is for student practice in Swedish massage and students are not qualified to practice on acute or complex medical conditions and that I am not seeking treatment for such conditions.	☐ I Understand
When scheduling a massage appointment, I must supply a valid credit card (Visa/Master Card) or valid gift certificate number in order to hold the appointment. If I fail to show for the appointment or do not give at least 24 hours' notice of cancellation my credit card or gift card will be charged. This helps ensure that our students can meet their graduation requirements.	☐ I Understand
If I am not able to keep a scheduled appointment, I must give at least 24 hours' notice. If I fail to give at least 24 hours' notice of cancellation or if I fail to show up for an appointment, I understand that I will be charged the full value of the appointment. If I fail to give at least 24 hours' notice and/or fail to show for an appointment on more than three occasions, I will lose the privilege of scheduling appointments at the clinic.	☐ I Understand
The client-therapist relationship is confidential and all information I provide will be treated in a professional and confidential manner. Students will share your health information with the Clinic Instructor(s) for the purpose of learning how to create the most effective and safe session for you based on your specific health history.	☐ I Understand
According to NYS Law, I **will be draped appropriately** at all times.	☐ I Understand
I have the right to request and require that any procedure or technique be modified, changed, or stopped at any time during the massage. If my request conflicts with any other Massage Clinic or NYS guideline to practice, a Clinic Instructor will be consulted.	☐ I Understand
The massage is for therapeutic purposes and the massage therapist has the right to be free from any unwanted, harmful, offensive, disrespectful behavior and/or physical contact from any client. A session can be terminated if a student therapist reports any inappropriate client behavior.	☐ I Understand
The Clinic staff will make every effort to accommodate your requests: i.e. specific student therapist, male or female therapist, firm or light pressure, etc. However, we **cannot guarantee all requests**. We are sometimes limited by the number of students available to partake in clinic.	☐ I Understand
I understand that, although I may request a specific student therapist, the Clinic Instructor may limit the number of times a student works on the same client. This may become necessary to ensure that the student therapist is working on a diverse population of clients to gain the requisite experience and meet graduation requirements.	☐ I Understand
The health information I give is accurate and it is my responsibility to update any and all health changes (including medications) at future appointments, as needed.	☐ I Understand
It may be necessary to obtain permission from my healthcare provider in order to receive or continue massage therapy at the OSTM Student Clinic.	☐ I Understand
A Clinic Instructor may observe, with minimal disruption, the student therapist during my massage session.	☐ I Understand

I have read and agree to the policies and terms as stated above.

Signature_____ Date _____