Colorado Mesa University
Campus Rec Services

Massage Therapy Health History Questionnaire

Client Name: _____ Today's Date: _____

Contact Number: _____ E-Mail: _____

Occupation: _____ Age: _____

How did you hear about us? _____

Have you ever had a professional massage before? Please circle one. Yes/No

If yes, please recall anything you liked or disliked. _____

_____

What type of pressure do you prefer? Light/Medium/Heavy

Please list any surgeries you have had & their approximate dates: _____

_____

Have you had any injuries in the last two years? _____

_____

Have you had any major illnesses/hospitalization in the last two years? _____

_____

Do you suffer from chronic illness or discomfort? _____

_____

Have you ever had any lymph nodes removed? _____

What medications are you taking? (Include over the counter & herbals) _____

_____

Do you have any skin conditions or disorders? (Rash, Shingles, Varicose Veins, Psoriasis, Skin Allergies, etc.)

_____

Irregular pulse: Yes/No Blood Pressure: Low/Normal/High

If pregnant, please indicate trimester. (Please circle one) 1st/2nd/3rd

What are your hobbies? (Activities, Sports, etc.) _____

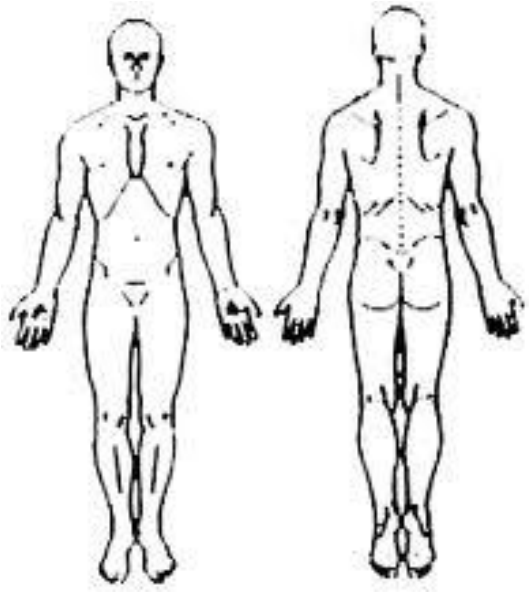
Please list your main reason for this visit: _____

_____

Please mark with an 'X' any areas of discomfort and give a brief description of the discomfort you are experiencing:

_____

_____



Please circle the following conditions that apply to you, past & present.
Please add your comments to clarify:

Headaches
Joint Stiffness/Swelling
Spasms/Cramps
Broken/Fractured Bones
Strains/Sprains
Tendonitis
Bursitis
Arthritis
Osteoporosis
Scoliosis
Bone or Joint Disease
Dizziness/Lightheadedness
Cosmetic Surgery
Nervous Stomach
Indigestion
Cold Sweats
Swollen Ankles
Pressure Sores
Varicose Veins
Blood Clots

Stroke
Heart condition
Allergies
Sinus Problems
Asthma
Lymphedema
Lymph Nodes
Rashes
Athletes Foot
Warts
Moles
Acne
Bladder Problems
Depression
Drug/Alcohol/Caffeine Use
Constipation
Intestinal Gas/Bloating
Colitis
Other Bowel Conditions
Other Infectious Disease (Explain)

Numbness/Tingling/Twitch
Chronic Pain
Sleep Disorders
Paralysis
Herpes/Shingles
Cerebral Palsy
Removed Epilepsy
Multiple Sclerosis
Muscular Dystrophy
Parkinson's Disease
Spinal Cord Injury
Shortness of Breath
Fainting
Cold Hands or Feet
Diabetes
Fibromyalgia
Post-Polio Syndrome
Cancer/HIV

Is there any other information your massage therapist should to know before beginning your massage?

_____

_____

Note: *Please be advised that your massage therapy session at the Hamilton Rec Center is for the purpose of stress relief from muscular tension or spasm and/or for increasing circulation, and to contribute to the wellbeing of my body and mind. Furthermore, understand that the massage therapist cannot diagnosis illness, disease, or any other physical or mental disorder.*

As such, the massage therapist does not prescribe medical treatment or pharmaceuticals, nor does he/she perform any spinal manipulations. Massage therapy is not a substitute for examinations and/or diagnosis and it is recommended that you see a physician for any physical or medical ailment.

Because a massage therapist must be aware of existing physical conditions, please make certain you have stated all known medical conditions and understand that the client assumes all responsibility and liability for information not disclosed to the massage therapist in this or future massage sessions.

Please document any changes to your current health on this form.

Massage Services Cancellation & Policy Agreement

Please understand and acknowledge the following policies by signing below:

- 24-Hour Notice of Cancellation is required in order to avoid
  - 1) being charged for any missed appointment
  - 2) to receive any credit for the appointment
  - 3) to be given the opportunity to reschedule any missed or late appointment.
- The Health History Questionnaire should be completed prior to my appointment time so that all appointments may start and end on time. If my forms are not completed prior to my appointment time, I understand that my massage appointment might begin late and time will not be made up.
- Please shower prior to your appointment.

_____
Client Name (Please Print)

_____ _____
Client Signature Date

_____ _____
Signature of Parent *(if under 18 years of age)* Date

We encourage you to tip your Massage Therapist if you enjoyed your massage service. Cash or check made out to your Massage Therapist is accepted. Thank you and we hope to see you again soon!

PAR-Q

Physical Readiness Questionnaire

Name _____ Date _____

DOB _____ Age _____ Phone _____

Regular exercise is associated with many health benefits. Increasing physical activity is safe for most people. However, some people should check with their doctor before they start becoming much more physically active. Completion of this questionnaire is a first step when planning to increase the amount of physical activity in your life. Please read each question carefully and answer each question honestly.

YES	NO	1) Has your doctor ever said that you have a heart condition and that you should only do physical activity recommended by a doctor?
YES	NO	2) Do you feel pain in your chest when you do physical activity?
YES	NO	3) In the past month, have you had chest pain when you were not doing physical activity?
YES	NO	4) Do you lose your balance because of dizziness or do you ever lose consciousness?
YES	NO	5) Do you have a bone or joint problem (for example, back, knee, or hip) that could be made worse by a change in your physical activity?
YES	NO	6) Is your doctor currently prescribing drugs (for example, water pills) for your blood pressure or heart condition?
YES	NO	7) Do you know of any other reason why you should not do physical activity?

- You should delay becoming much more active if you are not feeling well because of temporary illness such as a cold or a fever or if you are or may become pregnant. Talk to you doctor before you start becoming more active.
- If you answered YES to one or more questions, you will need to get a physical activity release from your doctor before becoming more physically active.
- If you honestly answered NO to all questions you can be reasonably certain you can safely increase your level of physical activity gradually.
- If your health changes so you then answer YES to any of the above questions, seek guidance from a physician.

"I have read, understood and completed this questionnaire. Any questions I had were answered to my full satisfaction."

Name _____

Signature _____ Date _____

Signature of Parent _____ Date _____
(If under 18 years of age)

Note: This physical activity clearance is valid for a maximum of 12 months from the date it is completed and becomes invalid if your condition changes so that you would answer YES to any of the seven questions.

HAMILTON RECREATION CENTER

WAIVER, RELEASE, ASSUMPTION OF RISK, AND INDEMNIFICATION AGREEMENT

Month and Year: _____ Participant Name: _____

In consideration for being permitted to use the Maverick Center facilities, including the Hamilton Recreation Center and Maverick Pavilion , the State of Colorado, Colorado Mesa University and its **Board of Trustees**, and with the understanding that such use is conditioned upon abiding by all policies and procedures and my execution of this waiver and release, for myself, my heirs and assigns, I hereby acknowledge, recognize and assume the risks involved in the use of the aforementioned facilities and any risks inherent in any other activities connected with the use of the Maverick Center Facilities. I expressly assume the risk of and accept full responsibility for any and all injuries (including death) and accidents which may occur as a result of my use of the Maverick Center, Hamilton Recreation Center, and Maverick Pavilion, and release from liability the State of Colorado, Colorado Mesa University and its Board of Trustees, and all of the officers, directors, agents, representatives, and employees of the foregoing entities.

I HEREBY WAIVE ANY CLAIM I MAY HAVE AS A RESULT OF MY PARTICIPATION IN THE ABOVE-REFERENCED RECREATION CENTER. I HEREBY AGREE TO INDEMNIFY, DEFEND AND HOLD HARMLESS THE STATE OF COLORADO, COLORADO MESA UNIVERSITY BOARD OF TRUSTEESAND ALL OF THE OFFICERS, DIRECTORS, AGENTS, REPRESENTATIVES, AND EMPLOYEES OF THE FOREGOING ENTITIES AGAINST ANY AND ALL CLAIMS, INCLUDING ATTORNEYS' FEES AND COSTS, WHICH MAY BE BROUGHT AGAINST ANY OF THEM BY ANYONE CLAIMING TO HAVE BEEN INJURED AS A RESULT OF MY PARTICIPATION IN THE USE OF THE HAMILTON RECREATION CENTER.

This waiver shall be governed in accordance with the laws of the State of Colorado, and venue for any action related to this waiver shall be in the City and County of Denver, Colorado. This waiver is intended as the complete integration of all understandings between the parties. No prior or contemporaneous addition, deletion, or other amendment hereto shall have any force or effect whatsoever, unless embodied herein in writing.

THIS IS A RELEASE OF LIABILITY. IF INDIVIDUAL IS UNDER EIGHTEEN (18) YEARS OF AGE, SIGNATURE OF A PARENT OR GUARDIAN IS REQUIRED. I HEREBY CERTIFY THAT I HAVE READ AND FULLY UNDERSTAND THIS WAIVER, RELEASE, ASSUMPTION OF RISK AND INDEMNIFICATION AGREEMENT.

_____

Signature of Participant Date

_____

Signature of Parent Date

(If participant is under 18 years of age)