Open Circle
Rhode Island

opencircleRI.com
kaeli@opencircleRI.com
401-338-5466

CONFIDENTIAL HEALTH FORM

First name _____ MI _____ Last name _____

○ Male ○ Female Date of Birth _____

Address _____ City _____ State _____ Zip _____

Home ✆ _____ Cell ✆ _____ Work ✆ _____

Email _____

Occupation _____

Emergency contact _____ Contact ✆ _____

How did you hear about Open Circle? _____

Have you ever had massage and/or bodywork before? ○ Yes ○ No

If yes, please list types _____

what did you find helpful? _____

Unhelpfull or ineffective? _____

Please describe anything you would like me to be aware of when giving you a massage

_____

Reason for this appointment? ☐ stress ☐ relaxation ☐ muscle fatigue ☐ injury ☐ other

If injury/other, please describe _____

Do you have any areas of abnormal nerve sensation (numbness/hypersensitivity)? ○ Yes ○ No

if yes, explain _____

has it been evaluated by a health professional? ○ Yes ○ No

Do you have any work-related physical complaints? ○ Yes ○ No

if yes, please describe _____

Please describe your exercise habits _____

Open Circle
Rhode Island

opencircleRI.com
kaeli@opencircleRI.com
401-338-5466

HEALTH HISTORY

please check or circle any conditions experienced in the last 3 years

- ☐ allergies
- ☐ angina / heart disease
- ☐ arthritis / joint pain
- ☐ asthma / respiratory disorder
- ☐ cancer
- ☐ cardiovascular/circulatory condition
- ☐ connective tissue condition
- ☐ contagious disease / condition
- ☐ diabetes
- ☐ disk injuries
- ☐ DVT/thrombosis/blood clots
- ☐ edema / swelling
- ☐ fibromyalgia
- ☐ hepatitis
- ☐ herpes
- ☐ high / low blood pressure
- ☐ inflammation
- ☐ insomnia
- ☐ immune disorder
- ☐ migraines
- ☐ headaches (cluster, tension, etc)
- ☐ osteoporosis / skeletal condition
- ☐ pregnancy
- ☐ reflux / GERD
- ☐ repetitive strain injuries
- ☐ sciatica
- ☐ skin conditions
- ☐ surgery / hospitalization
- ☐ whiplash
- ☐ varicose veins

Please list any major falls, injuries or illnesses suffered in the last 5 years

_____

_____

Please list allergies _____

If you are receiving this massage/bodywork because of injury or other medical condition, when and how did this condition begin? _____

_____

Has your injury/condition been evaluated/diagnosed by a health professional? ☐ Yes ☐ No

Name of health professional _____ city/town _____

Are you currently under a physician's care for any other condition? ☐ Yes ☐ No

if yes, condition _____

Please list below any medications that you are currently taking and the condition they are treating

_____

Because massage has an impact on the muscular, nervous and cardiovascular systems, it is important that your therapist be aware of any medications you are taking that might affect these systems. It is strongly recommended that you NOT take any medications/drugs, including over the counter medications and alcoholic beverages which alter your sensations, prior to your session. If it is necessary to take medication/other, please inform your therapist.

Please check any that apply:

cannot lie
- ☐ face down
- ☐ face up
- ☐ on right side
- ☐ on left side

- ☐ hearing impaired
- ☐ latex allergies
- ☐ lotion / oil allergies
- ☐ need help getting on / off massage table

I give my therapist permission to massage the following areas (you may modify this list at any time):

☐ legs ☐ hands ☐ neck ☐ face ☐ scalp ☐ feet
☐ back ☐ abdomen ☐ hips/gluts ☐ upper chest/collar bone area

I verify that all information provided is correct and current to the best of my knowledge.
I understand that if sending this form through email, Open Circle cannot guarantee its confidentiality while in transit. Forms may also be sent via USPS or brought in the day of your session.

signature _____ date _____

for office use only room temperature _____ bolstering _____ lotion/cream _____
music ◉ yes / no ○ other _____