

22 Oneawa Street  
Suite D Kailua, HI 96734  
808-853-0491



[www.windwardmassage.com](http://www.windwardmassage.com)  
monty@windwardmassage.com

### CLIENT HISTORY FORM

Please complete all sections of the questionnaire that pertain to your health concerns. Doing so will help us to more thoroughly understand your specific needs. All of your answers will be held absolutely confidential. If you have any specific concerns, please ask. Thank you.

#### PERSONAL INFORMATION

Name \_\_\_\_\_ Phone \_\_\_\_\_

Address: \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ ZIP \_\_\_\_\_ Birth Date \_\_\_\_\_

Occupation \_\_\_\_\_ Email \_\_\_\_\_

Referred by \_\_\_\_\_ Primary Physician \_\_\_\_\_

Type of Massage Experience: Swedish \_\_\_\_\_ Deep Tissue \_\_\_\_\_ Sport \_\_\_\_\_ Lymphatic \_\_\_\_\_ Other \_\_\_\_\_

#### CONDITION AND COMPLAINTS

Main reason for visit? \_\_\_\_\_ Physical aches/Pains? Where? \_\_\_\_\_

When did it begin? \_\_\_\_\_ What treatments have you tried? \_\_\_\_\_

#### EXERCISE

<input type="checkbox"/> Aerobics	<input type="checkbox"/> Sports	<input type="checkbox"/> Surfing	Details of Exercise: _____ _____ _____
<input type="checkbox"/> Running	<input type="checkbox"/> Biking	<input type="checkbox"/> Swimming	
<input type="checkbox"/> Walking	<input type="checkbox"/> Gym	<input type="checkbox"/> Other _____	

#### HEALTH AND MEDICAL HISTORY OF PAST AND PRESENT

<input type="checkbox"/> abdominal pain	<input type="checkbox"/> diabetes	<input type="checkbox"/> joint ache	<input type="checkbox"/> seizures
<input type="checkbox"/> accident	<input type="checkbox"/> decreased ROM	<input type="checkbox"/> upper back pain	<input type="checkbox"/> scoliosis
<input type="checkbox"/> allergies	<input type="checkbox"/> fatigue	<input type="checkbox"/> mid back pain	<input type="checkbox"/> sciatica
<input type="checkbox"/> anemia	<input type="checkbox"/> fibromyalgia	<input type="checkbox"/> lower back pain	<input type="checkbox"/> surgery
<input type="checkbox"/> arthritis, bursitis	<input type="checkbox"/> gout	<input type="checkbox"/> kidney disease	<input type="checkbox"/> stroke
<input type="checkbox"/> asthma	<input type="checkbox"/> headaches	<input type="checkbox"/> low blood sugar	<input type="checkbox"/> sleeplessness
<input type="checkbox"/> broken bones	<input type="checkbox"/> heart attack	<input type="checkbox"/> mastectomy	<input type="checkbox"/> stress
<input type="checkbox"/> cancer	<input type="checkbox"/> heartburn	<input type="checkbox"/> neck pain	<input type="checkbox"/> thyroid disease
<input type="checkbox"/> carpal tunnel syndrome	<input type="checkbox"/> hepatitis A, B, C	<input type="checkbox"/> pneumonia	<input type="checkbox"/> tuberculosis
<input type="checkbox"/> colitis	<input type="checkbox"/> high blood pressure	<input type="checkbox"/> shoulder pain	<input type="checkbox"/> varicose veins
<input type="checkbox"/> constipation	<input type="checkbox"/> HIV	<input type="checkbox"/> sprains	<input type="checkbox"/> whiplash

Special Notes: \_\_\_\_\_

#### DO YOU HAVE ANY OF THE FOLLOWING TODAY

<input type="checkbox"/> cold - flu	<input type="checkbox"/> inflammation	<input type="checkbox"/> numbness	<input type="checkbox"/> burn / sunburn
<input type="checkbox"/> headache	<input type="checkbox"/> irritated skin or rash	<input type="checkbox"/> open cuts, bruises	<input type="checkbox"/> severe pain

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**WAIVER**

I understand that all of the therapists who work at Windward Community Massage are independent contractors who are simply renting space. All therapist are responsible for their own professionalism, education, training, insurance, financial resources and behavior. I would not hold responsible Windward Community Massage for any transgressions (personal or professionally), which may occur between myself and any of the therapists who may be working out of this office.

\_\_\_\_\_  
Initial & Date

I understand that this massage / bodywork is not a substitution for medical care and that no diagnosis will be made. The massage / bodywork I receive is provided for the basic purpose of relaxation and relief of muscular tension. If I experience any pain or discomfort during this session, I will immediately inform the practitioner so that the pressure and / or stroke maybe adjusted to my comfort level or immediately stopped. Because massage / bodywork should not be carried out under certain medical conditions. I confirm that I have stated all my known medical conditions, and answered all questions honestly. I also understand that any illicit or sexually suggestive remarks and/or advances made by me will result in immediate termination of the session, and I will be liable for payment of the scheduled appointment.

\_\_\_\_\_  
Initial & Date

I understand and acknowledge there is a 24 hour cancellation policy in effect and agree, that I should pay for all sessions scheduled which are not met or cancelled within a 24 hour period.

\_\_\_\_\_  
Client Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Practitioner Signature

\_\_\_\_\_  
Date