

Nathi's Tuina Massage Fusion.

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HEALTH HISTORY FORM

PRIVATE AND CONFIDENTIAL

Name: _____

Date of initial visit: _____

Address: _____

Phone number: _____

Email ID: _____

Date of birth: _____

Referred by: _____

Physician name: _____

Allergies: _____

Sports & activities: _____

Current medications: _____

Are you under medical care for any of the following: (circle) Please indicate which of the following applies to you.

The information obtained will be used to help us determine how to best tailor our services and will be treated as private and confidential.

heart conditions

high/low blood pressure

fainting or dizziness

varicose veins

phlebitis/circulatory problems

headaches or migraine

neck injury

back injury

jaw or ear pain

osteoporosis

rheumatoid arthritis

osteoarthritis

cancer

kidney disease

skin conditions

diabetes

asthma/respiratory

fibromyalgia

Crohn's disease

pelvic inflammatory disease

epilepsy

nervous disorders

whiplash

other:

Reason for Visit:

Have you received care from any of the following for your current condition?

Physiotherapist

Chiropractor

Massage Therapist

Acupuncture

Have you had surgery in the past? Y N If yes, for what? _____

Have you had any fractures/sprains in the past? Y N If yes, where? _____

Have you had any serious illnesses in the past? Y N If yes, what? _____

Cont...

**INFORMED CONSENT TO MASSAGE THERAPY TREATMENT
RELEASE OF LIABILITY AND DATA PRIVACY**

- I hereby consent for my therapist to treat me with massage therapy for the above noted purposes including such assessments, examinations and techniques, which may be recommended, by my therapist.
- I acknowledge that the therapist is not a physician and does not diagnose illness or disease or any other physical or mental disorder. I clearly understand that massage therapy is not a substitute for a medical examination. It is recommended that I attend my personal physician for any ailments that I may be experiencing.
- I acknowledge that no assurance or guarantee has been provided to me as to the results of the treatment. I acknowledge that with any treatment there can be risks and those risks have been explained to me and I assume those risks.
- I acknowledge and understand that the therapist must be fully aware of my existing medical conditions. I have completed my medical history form as provided by my therapist and disclosed to the therapist all of those medical conditions affecting me. It is my responsibility to keep the massage therapist updated on my medical history. The information I have provided is true and complete to the best of my knowledge.
- I have read the above noted consent and I have had the opportunity to question the contents and my therapy. I will indemnify and hold harmless, the owner and the operator of Nathi's Tuina Massage Fusion, together with their officers, directors, shareholders, employees, agents, and representatives and all successors and/or assigns from and against any and all actions, cost, claims, losses, expenses, in any manner resulting from your use of the Services.
- I further understand it is my sole responsibility to determine my suitability and personal knowledge on the use of the Services.
- I agree that these terms and conditions shall apply to my current and future use of the Services.
- I hereby agree that any dispute or claim that arises out of or is related to use of the Services is subject to the law of **Bermuda** and the exclusive jurisdiction of the courts of **Bermuda**.
- Nathi's Tuina Massage Fusion will retain your personal data and preferences on its records to provide you with a more tailored service for your future services. Should you prefer NTMF not to use your data for this purpose, please tick the box here
- NTMF will use your personal data to contact you regarding news and promotional offers. If you do not want NTMF to contact you for this purpose, please tick the box here
- You acknowledge that you have read this Release of Liability and Data Privacy statement carefully and understand its meaning and you agree to be bound by this Release of Liability and Data Privacy statement.

Signed

Date

Patient Name _____ Signature of Patient/Guardian _____