PERSONAL HEALTH INFORMATION

PERSONAL DATA

Name: _____ Date:_____Referred by: _____

Address: _____ Home Phone #: _____

City, State, & Zip: _____Work/Cell Phone#: _____

Date of Birth:_____Occupation: _____Employer: _____

Email:_____Primary Care Physician: _____

MASSAGE/TREATMENT HISTORY

Have you ever received a professional massage? ☐ Yes Date of last massage: _____ ☐ No

What results do you want from your massage sessions? _____

_____

What areas of your body would you like the therapist to focus on?

_____

Are there any areas of your body that you would not like to have worked on?

_____

Are you currently under the care of a medical practitioner? ☐ Yes ☐ No If yes, please explain:

_____

Please list stress reduction and exercise activities: _____

Please list any medications you are taking, including over-the-counter drugs (such as: aspirin, ibuprofen, etc): _____

Any allergies? _____

Please list any previous surgeries, injuries, and/or accidents, including year and any treatment received:

_____

_____

HEALTH HISTORY Please check all that apply, specifying past or current and the location.

MUSCULO-SKELETAL

Past	Current		Past	Current	
☐	☐	Bone or joint disease _____	☐	☐	Jaw pain, TMJ _____
☐	☐	Neck, shoulder, arm pain _____	☐	☐	Arthritis _____
☐	☐	Tendonitis _____	☐	☐	Lupus _____
☐	☐	Headaches, head injuries _____	☐	☐	Sprain(s)/Strain(s) _____
☐	☐	Bursitis _____	☐	☐	Low back, hip, leg pain _____
Past	Current		Past	Current	
☐	☐	Spasm(s)/Cramp(s) _____	☐	☐	Broken/Fractured bones _____
☐	☐	Fibromyalgia _____	☐	☐	Other _____

CIRCULATORY/RESPIRATORY

Past Current

☐ ☐ Heart condition _____
☐ ☐ Varicose veins _____
☐ ☐ Blood clots _____
☐ ☐ High/Low blood pressure _____
☐ ☐ Thrombophlebitis _____
☐ ☐ Lymphedema _____
☐ ☐ Breathing difficulty _____
☐ ☐ Sinus problems _____
☐ ☐ Other _____

NERVOUS

☐ ☐ Numbness/Tingling _____
☐ ☐ Herpes/Shingles _____
☐ ☐ Multiple Sclerosis _____
☐ ☐ Chronic pain _____
☐ ☐ Sleep disorder _____
☐ ☐ Fatigue _____
☐ ☐ Seizure disorder _____
☐ ☐ Other _____

INFECTIOUS DISEASE

☐ ☐ Disease name/description _____
_____
☐ ☐ Disease name/description _____
_____

Past Current

☐ ☐ Rashes _____
☐ ☐ Eczema/Psoriasis _____
☐ ☐ Warts _____
☐ ☐ Open wounds/Bruises _____
☐ ☐ Athletes' foot/Fungal infection _____
☐ ☐ Other _____

DIGESTIVE/URINARY

☐ ☐ Constipation/Gas/Bloating _____
☐ ☐ Cirrhosis _____
☐ ☐ Irritable bowel syndrome _____
☐ ☐ Diverticulitis _____
☐ ☐ Renal failure _____

REPRODUCTIVE

☐ ☐ Pregnancy: Stage _____
☐ ☐ PMS _____
☐ ☐ Endometriosis _____
☐ ☐ Other _____

OTHER

☐ ☐ Cancer/Tumor(s) _____
☐ ☐ Auto-immune disorder _____
☐ ☐ Diabetes _____
☐ ☐ Eating disorder _____
☐ ☐ Depression _____

ADDICTION(S)

Past Current ☐ ☐ Drug(s) _____
Past Current ☐ ☐ Alcohol _____
Past Current ☐ ☐ Nicotine _____
Past Current ☐ ☐ Caffeine _____

It is my choice to receive massage therapy and I realize the treatment is being given for the well being of my body and mind. This can include relief from muscular tension, spasm or pain, stress reduction or for increasing circulation and energy flow. I agree to communicate with my practitioner if, at any time, I feel that my well-being has been compromised.

I understand that massage practitioners do not diagnose illness, disease, or any physical or mental disorder; not do they prescribe medical treatment or pharmaceuticals or perform spinal manipulations. I acknowledge that massage is not a substitute for medical examination or diagnosis and that it is recommended that I see a primary health care provider for that service.

I have stated all medical conditions of which I am aware and will update the massage practitioner of any changes to my health status.

SIGNATURE: _____ **DATE:** _____