PERSONAL HEALTH INFORMATION

PERSONAL DATA

Email: _____

Name: _____ Date: _____ Referred by: _____

Address: _____ Phone - Day: _____

City/State/Zip: _____ Phone - Eve: _____

Birthday: _____ Occupation/Employer: _____

Primary Health Care Provider: _____ Phone: _____

Permission to consult with primary provider? Please initial if yes. ☐ Yes _____ ☐ No

Emergency contact: _____ Phone: _____

MASSAGE HISTORY/TREATMENT INFORMATION

Have you ever received a professional massage? ☐ Yes ☐ No If yes, frequency _____ Date of last massage _____

What results do you want from your massage sessions? _____

Prioritze the areas of your body that you would prefer to be massaged. _____

Please check the areas of your body that you give permission to receive massage:

☐ back ☐ legs ☐ buttocks ☐ arms ☐ abdomen ☐ chest ☐ neck ☐ head ☐ face ☐ other _____

Are you currently seeing a medical practitioner? Please explain if yes. ☐ Yes ☐ No _____

Are you currently seeing a psychotherapist or are you attending regular support group meetings? Please explain if yes. ☐ Yes ☐ No _____

List stress reduction and exercise activities. Include frequency. _____

List current medications, including aspirin, ibuprofen, etc. _____

PREVIOUS HISTORY (Include year and treatment received)

Surgeries: _____

Accidents: _____

HEALTH HISTORY

MUSCULO-SKELETAL

_____ bone or joint disease _____
_____ tendonitis _____
_____ bursitis _____
_____ broken/fractured bones _____
_____ arthritis _____
_____ sprains/strains _____
_____ low back, hip, leg pain _____
_____ neck, shoulder, arm pain _____
_____ headaches/head injuries _____
_____ spasms/cramps _____
_____ jaw pain/TMJ _____
_____ lupus _____
_____ other _____

CIRCULATORY

_____ heart condition _____
_____ varicose veins _____
_____ blood clots _____
_____ high blood pressure _____
_____ low blood pressure _____
_____ lymphedema _____
_____ breathing difficulty _____
_____ sinus problems _____
_____ allergies _____
_____ other _____

INFECTIOUS DISEASE

_____ disease name(s): _____
_____
_____

SKIN

_____ allergies _____
_____ rashes _____
_____ athletes foot _____
_____ warts _____
_____ other _____

DIGESTIVE

_____ constipation _____
_____ gas/bloating _____
_____ diverticulitis _____
_____ irritable bowel syndrome _____
_____ other _____

NERVOUS SYSTEM

_____ herpes/shingles _____
_____ numbness/tingling _____
_____ chronic pain _____
_____ fatigue _____
_____ sleep disorders _____
_____ other _____

REPRODUCTIVE

_____ pregnant? Stage _____
_____ PMS _____
_____ other _____

OTHER

_____ cancer/tumors _____
_____ diabetes _____
_____ eating disorders _____
_____ depression _____
_____ drug/alcohol addiction _____
_____ nicotine/caffeine addiction _____

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

I understand that massage practitioners do not diagnose illness, disease, or any physical or mental disorder; nor do they prescribe medical treatment, pharmaceuticals, or perform spinal thrust 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 that I am aware of and will update the massage practitioner of any changes in my health status.

SIGNATURE: _____ DATE: _____