Personal Health Information

Personal Data:

Name: ______________________________ Date: __________ Referred by: ____________

Address: ______________________________ Phone - Home: ______________________

City/Sate/Zip: ___________________________ Phone - Work: ______________________

Birthday Month: __________________________ Phone - Cell: ______________________

Occupation: ______________________________

Emergency Contact: ________________________ Phone: ___________________________

Massage History/Treatment Information:

Have you ever received a professional massage? ___ yes ___no If yes, frequency ________________

What results do you want from your massage sessions? ________________________________

____

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

___ back ___ legs ___ buttocks ___ arms ___ abdomen ___ chest ___ neck ___ head ___ face

List stress reduction and exercise activities. Include frequency. ___________________________

____

Are you currently seeing a medical practitioner for a specific condition? ___ Yes ___ No If yes, please explain.

____

List current medications, including aspirin, ibuprofen, vitamins, etc. __________________________

____

Are you currently seeing a psychotherapist or are you attending regular support group? ___ Yes ___ No If yes, please explain. ____

Previous History - Include year and treatment received:

Surgeries: ____

____

____

Accidents: ____

____

____

Personal Health Information

Musculo-Skeletal

____ tendonitis ____________________________

____ bursitis ______________________________

____ broken/fractured bone _________________

____ 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 _______________________

____ other ________________________________

Infectious Disease

____ disease name (s) ______________________

____

Skin

____ allergies ______________________________

____ rashes ________________________________

____ athletes foot ___________________________

____ other _________________________________

Digestive

____ constipation ____________________________

____ gas/bloating ____________________________

____ diverticulitis ____________________________

____ irritable bowel syndrome ________________

____ other _________________________________

Nervous System

____ herpes/shingles _________________________

____ numbness/tingling ______________________

____ chronic pain ____________________________

____ fatigue ________________________________

____ sleep disorders _________________________

____ other _________________________________

Reproductive

____ pregnant Due Date ______________________

____ PMS __________________________________

____ other _________________________________

Other

____ cancer/tumors ________________________

____ diabetes _______________________________

____ depression _____________________________

____ 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: ______________________