

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: _____

MESSAGE 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? _____

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

Are there any areas of your body that you prefer not be massaged? _____

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: _____

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: _____

* 24 Hour Cancellation Policy *