PERSONAL HEALTH INFORMATION

PERSONAL DATA

Name:_____ **Date:**_____ **Referred by:**_____

Address:_____ **Phone – Day:**_____

City/State/Zip:_____ **Phone – Eve:**_____

Birthday:_____**Email:**_____ **Occupation/Employer:**_____

CONTACT INFORMATION

Emergency Contact:_____ **Phone:**_____

HEALTH CARE PROVIDER

Primary Physician:_____ **Phone:**_____

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

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?_____

_____

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

_____

Prioritize the areas of your body that you prefer not be massaged:_____

_____

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

_____

_____

List stress reduction and exercise activities. Include frequency:_____

_____

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

_____

PREVIOUS HISTORY

Surgeries:_____

_____

Accidents: _____

_____

_____

- **Cancellations require 24-hour notice, otherwise, a fee for the full session will be charged. Exceptions will be made for illness, bad weather or other emergency at the discretion of the practitioner.**
- **Clients arriving late for an appointment will be charged for the full session and the session will end at the scheduled time.**

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 _____
- ☐ thrombophlebitis (DVT) _____
- ☐ blood clots _____
- ☐ high blood pressure _____
- ☐ low blood pressure _____
- ☐ lymphadema _____
- ☐ 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 _____

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 that my well-being is 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 those services.

I have stated all medical conditions that I am aware of and will update the massage practitioner of any change in my health status

SIGNATURE: _____ **DATE:** _____