

Personal Health Information

p. 1 of 2

Personal Data

Name: _____
Address: _____
City/State/Zip: _____
Birthday: _____
Primary Health Care Provider: _____

E-mail address: _____
Date: _____ Referred By: _____
Phone – Cell: _____
Phone – Other: _____
Occupation/Employer: _____
Phone: _____

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?

Prioritize 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

List stress reduction and exercise activities. Include frequency.

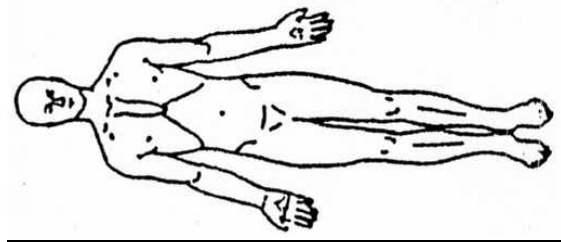
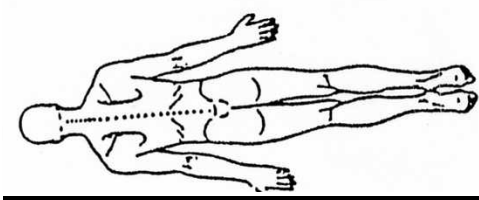
List current medications; including aspirin, ibuprofen, etc.

Previous History (Include year and treatment received)

Surgeries

Accidents

Please mark the areas where you have tension, discomfort, or pain:



Current Health History

(Continued)

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 # Weeks _____
- 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 improving circulation or energy flow. I agree to communicate to my massage therapist the depth of pressure that is therapeutic.

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 manipulations. I acknowledge that massage is not a substitute for a medical examination or diagnosis, and that it is recommended that I see a primary health care provider for that service.

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

Your Signature _____ Date _____



Ann Scarborough, BA, LMT
12400 Pillsbury Avenue South
Burnsville, MN 55337
(952) 994-1790 cell
djmwellness@aol.com
www.djmwellness.com