PERSONAL HEALTH INFORMATION

PERSONAL DATA

E-mail address: ______________________

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? ______________________

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 ______________________

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: ______________________

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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: ____________

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