PERSONAL HEALTH INFORMATION

PERSONAL DATA

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: _____

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 intake _____
____ nicotine/caffeine intake _____

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: _____