MASSAGE CLIENT HEALTH HISTORY FORM

Today's Date: ____________

Name: ____ Date of Birth: ___________________ Age: ___________

Street Address: ____ City: ______________________ State:______ Zip:___________

Email Address: ____ Home Phone: ___________________ Cell Phone: ___________________

Occupation: ______________________________ Employer: ____________________________________ Work Phone: ________________

Gender: □Male □Female Marital Status: ______ ____________ Whom may we thank for referring you? ________________________

Emergency Contact: ____ Relationship: ___________________ Phone: __________________

Please mark (X) each condition that you currently have. Put a (P) for any condition you have had in the past. Give details below.
(Note: Massage/bodywork for individuals with certain medical conditions may not be recommended. In some cases a referral from your primary care provider may be required prior to services being provided.)

___ High / Low Blood Pressure (Circle One)
___ Stroke
___ Heart Attack
___ Heart Disease
___ Other circulatory disorder
___ Kidney disorder
___ Blood clots
___ Varicose Veins (raised)
___Easy bruising
___Currently Pregnant? (If yes, due date_______)
___ Diabetes
___ Cancer/Malignancy
___ HIV/AIDS
___ Any contagious disease
___ Skin rash/condition (Contagious? Y N)
___ Allergies
___ Diverticulitis
___ Chronic Diarrhea
___ Current Urinary Infection
___ Arthritis
___ Herniated Disc(s)
___ Epilepsy or Seizures
___ Mental Illness
___ Neck Injury/Whiplash
___Headaches
___ Jaw pain/TMJ problems
___Fibromyalgia
___ Lupus

Details on above conditions that you have or have had: ____

____

Any other medical conditions not listed above: ____

History of fractures (include description & dates): ____

History of surgeries (include description & dates) : ____

Are you presently under the care of a physician, chiropractor or other practitioner? □YES □NO
If yes, for what condition? ____

Are you presently taking any medications? □YES □NO If yes, list medication and reason you are taking it below.
____

____

Exercise Level: □None □Moderate □Daily □Heavy **Have you ever received a professional massage?** □YES □NO

What is your goal for your visit today? ____

What is your major complaint? ____

Do you have any minor complaints? ____

CONSENT FOR MASSAGE THERAPY

It is my choice to receive massage therapy. I realize that the treatment is given for the well-being of my body and mind. This includes stress reduction, relief from muscular tension, spasm, pain or for increasing circulation and energy flow. ***I agree to communicate with my therapist any time I feel my well-being is compromised.***

I understand that massage therapists do not diagnose illness, disease or any physical or mental disorder; nor do they prescribe medical treatment, pharmaceuticals, supplements, remedies 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 therapist of any changes in my health status.

Patient Signature: ____ Date: _______________ Witness: ______________________________