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_______________________

Emergency Contact____Phone________________________

Massage History/Treatment Information

Have you ever received a professional massage?____

If yes, frequency____Date of last massage________________________

What results do you want from your massage session?____

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List stress reduction and exercise activities. Include frequency.______________________________________

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

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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 bone________________________________
___Arthritis________________________________
___Sprain/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/low blood pressure________________________________
___Lymph edema________________________________
___Breathing difficulty________________________________
___Sinus problems________________________________
___Other________________________________

Skin

___Allergies________________________________
___Rashes________________________________
___Athletes foot________________________________
___Warts________________________________
___Other________________________________

Digestive

___Constipation________________________________
___Gas/bloating________________________________
___Diverticulitis________________________________
___Irritable bowel syndrome________________________________
___Other________________________________

It is my choice to receive massage therapy. I realize that the treatment is being given for my well being of mind and body. This includes stress reduction, relief from muscular tension, spasm or pain, or for increasing circulation. I agree to communicate with my practitioner any time I feel 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 manipulation. I acknowledge that massage therapy is not a substitute for medical examination or diagnosis.

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_____________________

***Please inform the office if you cannot make a massage appointment at least 24 hours before your scheduled appointment.**