

Massage Therapy Health History Form - Confidential

Name: _____ Birthdate: _____ Referred by: _____

Address: _____ City: _____ State: _____ Zipcode: _____

Phone: (H) _____ Work: _____ Email: _____

When was your last massage? _____

Areas of focus for today's visit: _____

List any accidents, fractures, and surgeries in the past 5 years:

How often & what type of exercise do you do? _____

Describe any current or ongoing musculoskeletal pain or stiffness & current medications:

Are you pregnant? (No) _____ (Yes) _____ Due date: _____

Allergies to any oils, lotions,scents? (No) _____ (Yes) please list: _____

Please check all that apply

- | | | |
|--|--|---|
| <input type="checkbox"/> Muscle Tightness | <input type="checkbox"/> Fibromyalgia | <input type="checkbox"/> Kidney problems |
| <input type="checkbox"/> Muscle Cramps | <input type="checkbox"/> Tendonitis | <input type="checkbox"/> Liver problems |
| <input type="checkbox"/> Wear Hearing Aid | <input type="checkbox"/> Swollen extremities | <input type="checkbox"/> Sciatica |
| <input type="checkbox"/> Gall Bladder problems | <input type="checkbox"/> Numbness | <input type="checkbox"/> Herniated Disc |
| <input type="checkbox"/> PMS/painful periods | <input type="checkbox"/> Cold Hands or Feet | <input type="checkbox"/> Osteoporosis |
| <input type="checkbox"/> Fluid retention | <input type="checkbox"/> Varicose Veins | <input type="checkbox"/> Seizures/convulsions |
| <input type="checkbox"/> Depression | <input type="checkbox"/> Easy Bruising | <input type="checkbox"/> Hepatitis |
| <input type="checkbox"/> Dizziness | <input type="checkbox"/> Low Blood Pressure | <input type="checkbox"/> Scoliosis |
| <input type="checkbox"/> Skin irritation | <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Sports Injuries |
| <input type="checkbox"/> Loss of Balance | <input type="checkbox"/> Heart Disease | <input type="checkbox"/> Chronic Fatigue Syndrome |
| <input type="checkbox"/> Inner ear problem | <input type="checkbox"/> Allergies | <input type="checkbox"/> Diabetes |
| <input type="checkbox"/> Night Sweats | <input type="checkbox"/> Migraines | <input type="checkbox"/> Cancer |
| <input type="checkbox"/> Sleep problems | <input type="checkbox"/> Asthma | <input type="checkbox"/> Hypoglycemia |
| <input type="checkbox"/> Fatigue | <input type="checkbox"/> Joint pain | <input type="checkbox"/> Arthritis |

This information and our sessions are treated with confidentiality. Please give feedback at any time during or after the massage. This communication between you and I during the massage will facilitate a more productive outcome from the session for you.

I, the client, understand that the work done during this massage does not constitute medical treatment and that the massage therapist is not a physician. The session is a form of health and wellness maintenance utilizing the techniques of massage and holistic healing, I, the client, take responsibility for alerting the therapist to any conditions that might affect this work. It is recommended that I, the client, see a physician for any ailments I might have. Any suggestions made by the massage therapist are recommendations not prescriptions.

My signature below indicates that I understand and agree to the above conditions.

Signature: _____ Date: _____