



## Personal Health Information

Client Name: _____	Date: _____	Referred By: _____	
Height: _____	Weight: _____	Sex (M/F): _____	Date of Birth: _____
Address: _____	Phone (Home): _____		
City/State/Zip: _____	Phone (Work): _____		
Emergency Contact: _____	Phone: _____		
Occupation: _____	Email: _____		

### Massage History/Treatment Information

Have you ever received a professional massage (Y/N): \_\_\_\_\_ If Yes, frequency: \_\_\_\_\_

Date of last massage: \_\_\_\_\_

Are there any areas of your body you **do not** want massaged: \_\_\_\_\_

Are you currently seeing a medical practitioner (Y/N)? \_\_\_\_\_ If yes, please explain:

Are you currently seeing a psychotherapist or attending regular support group meetings (Y/N): \_\_\_\_\_

If yes, please explain: \_\_\_\_\_

Please list exercise and stress reduction activities and frequency: \_\_\_\_\_

Please list current medications (both prescription and over-the-counter): \_\_\_\_\_

### Medical History *(include year and treatment received)*

Surgeries: \_\_\_\_\_

Accidents: \_\_\_\_\_

\_\_\_\_\_ (over)



**Medical History (cont.)**

**Musculo-Skeletal**

- Bone or joint disease
- Tendonitis
- Bursitis
- Broken/fractured bones
- Arthritis
- Sprains/strains
- Low back, hip, leg pain
- Headaches/head injury
- Jaw pain/TMJ
- Lupus
- Other

**Infectious Disease**

- Disease name(s)
- \_\_\_\_\_
- \_\_\_\_\_
- \_\_\_\_\_
- \_\_\_\_\_
- \_\_\_\_\_
- \_\_\_\_\_

**Circulatory**

- Heart condition
- Varicose veins
- Blood clots
- High blood pressure
- Low blood pressure
- Lymphedema
- Breathing difficulty
- Sinus problems
- Allergies
- Other

**Skin**

- Allergies
- Rashes
- Athlete's foot
- Warts
- Other

**Reproductive**

- Pregnant? Stage?
- \_\_\_\_\_
- PMSther

**Digestive**

- Constipation
- Irritable bowel syndrome
- Gas/bloating
- Diverticulitis
- Other

**Nervous System**

- Herpes/shingles
- Numbness/tingling
- Chronic pain
- Fatigue
- Sleep disorders
- Other

**Other**

- Cancer/tumors
- Diabetes
- Eating disorders
- Depression
- Drug/alcohol addiction
- Nicotine/caffeine addiction

Explain all yes answers and provide dates for occurrences: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

**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 massage therapist any time I feel my well being is being compromised.**

**I understand that massage therapists do not diagnose illness, disease, or any physical or mental disorders, 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 therapist of any changes in my health status.**

**SIGNATURE: \_\_\_\_\_ DATE: \_\_\_\_\_**