

PERSONAL HEALTH HISTORY

Personal Data

Name _____ Date _____

Referred by _____ Home Phone _____ Work _____

Street _____ City _____ Zip _____

Email _____ Date of Birth _____

Emergency Contact _____ Phone _____

Primary Health Care Provider _____ Phone _____

Permission to consult with PCP? Please initial if yes. Yes _____ No _____

Insurance Company _____ Policy # _____ ID# _____

Massage History/ Treatment Information

Have you ever received a professional massage? _____ Date of last massage _____

What results would like to achieve from your sessions? _____

Prioritize the areas of your body that you would like to focus on _____

Please indicate with a check mark any areas that you **do not** wish to have massaged. Back ___ Legs ___ Buttocks ___ Arms ___ Abdomen ___

Chest ___ Neck ___ Face ___ Feet ___ Other _____

Please list any activities that reduce stress in your life and the frequency. _____

Health History

Surgeries in the previous five years (please indicate date) _____

Surgeries more than five years ago _____

Describe injuries or accidents in the previous five years and the date of the injury _____

Injuries or accidents more than five years ago _____

Are you currently seeing your PCP for any reason and if so, why? _____

Please list any medications or supplements you are currently taking and the condition for which they are taken. _____

Please check any of the following conditions that you have experienced.

Musculoskeletal

- Fibromyalgia
- Rheumatoid Arthritis
- Osteoarthritis
- TMJ
- Sprains/Strains/Tendonitis
- Carpal Tunnel Syndrome
- Thoracic Outlet Syndrome
- Cramping/Spasms/Soreness

Circulatory

- Anemia
- Thrombophlebitis
- Heart Disease
- High or low BP
- Varicose Veins
- Diabetes
- Clotting Disorders

Skin

- Boils
- Fungal Infection
- Herpes Simplex
- Warts
- Eczema
- Skin Cancer

Nervous System

- Multiple Sclerosis
- Numbness/Tingling
- Headaches
- Stroke
- Seizure Disorders
- Sleep Disorders

Digestive

- Constipation
- Gas/Bloating
- Diverticulitis
- Colitis
- Other _____

Reproductive

- Breast Cancer
- Endometriosis
- PMS
- Prostrate Cancer
- Pregnancy? ____
- Other

Other

- Depression
- Sinusitis
- Allergies (please list)

- Asthma
- Tuberculosis

- Emphysema
- Chronic Fatigue

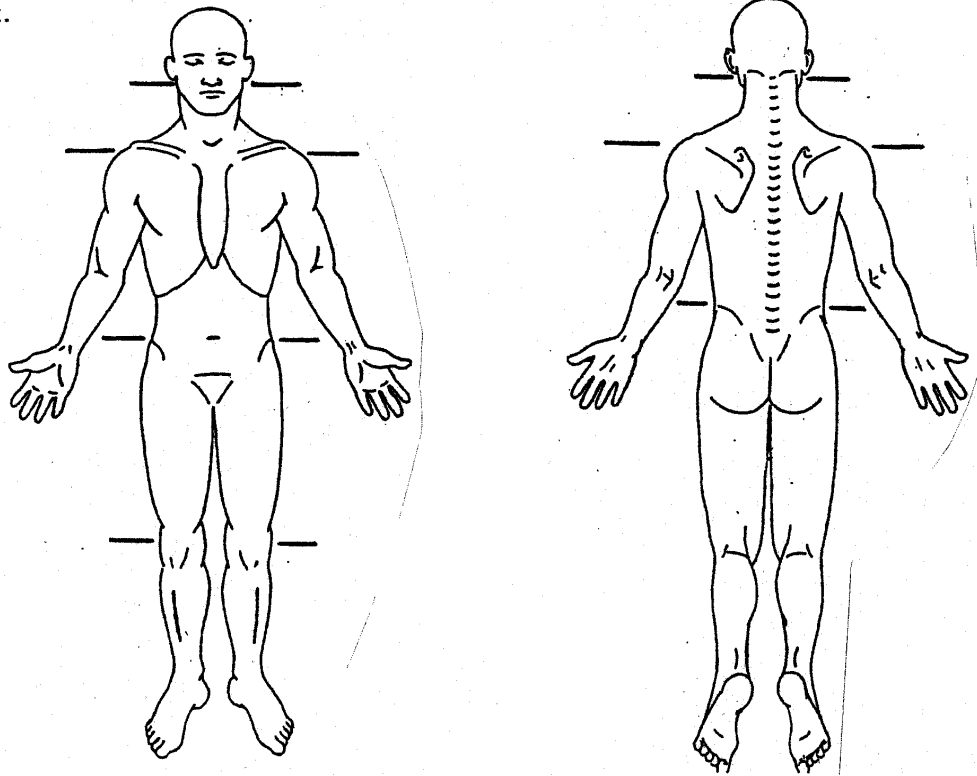
Please indicate your use of the following

Light Moderate Heavy

- | | | | |
|----------|-------|-------|-------|
| Caffeine | _____ | _____ | _____ |
| Alcohol | _____ | _____ | _____ |
| Exercise | _____ | _____ | _____ |
| Nicotine | _____ | _____ | _____ |

Please list any concerns or any other information that you feel will help me to serve you better. _____

On the figure below please indicate any area where you are currently experiencing pain and/ or discomfort.



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 _____