Health History Form

NAME_____TODAY'S DATE_____/_____/_____
ADDRESS_____ MALE / FEMALE (circle)
CITY/STATE/ZIP_____DATE OF BIRTH _____/_____/_____
PHONE CONTACT_____ E-MAIL_____
EMERGENCY CONTACT_____EC #_____
Referred by_____Have you ever received a massage therapy treatment? Y / N
Reason for your massage therapy appointment today _____
_____

MEDICAL HISTORY

Are you currently being treated under care of a physician? Y / N Date of last physical exam_____
PHYSICIAN _____ Phone Number_____
Are you pregnant? Y / N If yes, what week?_____
List any current diagnosis and treatment you are receiving_____
List present medications and for what conditions_____
List dietary and herbal supplements, vitamins, or homeopathic remedies_____
_____
List any major surgery and date/year_____
List any broken bones or sprains with location_____
List any joint replacement(s) with location_____
List any skin conditions_____ Do you bruise easily? Y / N
List any allergies_____ To lotions Y / N To scents Y / N
List any contagious condition(s)_____

DAILY HEALTH HABITS

Rate your current stress level ▪ High ▪ Moderate ▪ Low ▪ Minimum
Occupation_____ Physical Activities_____

Circle your most frequent body position(s)

- ▪ Standing ▪ Sitting ▪ Stooping ▪ Lifting ▪ Bending
- ▪ Leaning Forward ▪ Kneeling ▪ Head held long hours in abnormal position ▪ Repetitive movement

Specify_____

Rate your degree of body flexibility ▪ Excellent ▪ Good ▪ Fair ▪ Poor
▪ Other_____

Circle areas of concern
Musculoskeletal

- ▪ Aching muscles ▪ Aching joints ▪ Neck pain ▪ Tension Headaches ▪ Shoulder pain
- ▪ Wrist/elbow ▪ Mid-back pain ▪ Low back pain ▪ Hip pain ▪ Knee ankle pain

Neurological ▪ Sharp/shooting sensation ▪ Numbness

- ▪ Neuritis or Neuralgia
- ▪ Difficulty sleeping
- ▪ Difficulty relaxing
- ▪ Other

Cardiovascular

- ▪ High blood pressure
- ▪ Low blood pressure
- ▪ Swollen feet or ankles
- ▪ Varicose veins
- ▪ Cold hands/feet
- ▪ Cerebral vascular attack or stroke

When_____ Other_____

Digestive ▪ Indigestion/Bloated stomach ▪ Constipation ▪ Loose bowels/diarrhea ▪ Ulcers

Genitourinary ▪ Bladder problems ▪ Kidney problems

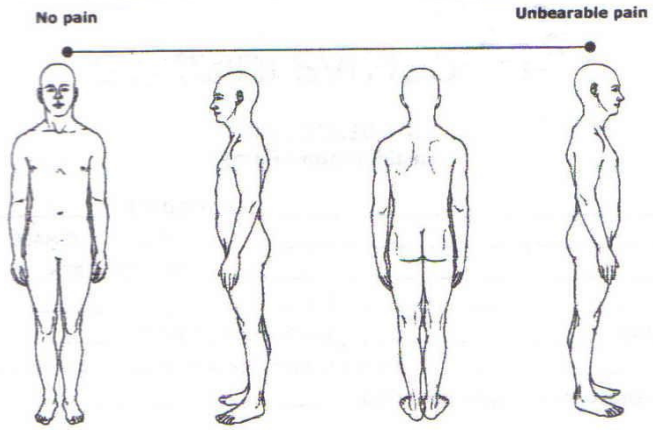
Other_____

Females: If you are currently on your menses, are you experiencing any breast or abdominal discomfort? Y / N

Endocrine ▪ Diabetic ▪ Other_____

Do you have any other medical condition not listed?_____

Please circle or place an "x" on any areas of discomfort or pain. Rate your current pain level:



I understand that the massage/bodywork I receive is provided for the basic purpose of relaxation and relief of muscular tension. If I experience any pain or discomfort during this session, I will immediately inform the practitioner so that the pressure and/or strokes may be adjusted to my level of comfort. I further understand that massage or bodywork should not be construed as a substitute for medical examination, diagnosis, or treatment and that I should see a physician, chiropractor, or other qualified medical specialist for any mental or physical ailment of which I am aware. I understand that massage/bodywork practitioners are not qualified to perform spinal or skeletal adjustments, diagnose, prescribe, or treat any physical or mental illness, and that nothing said in the course of the session given should be construed as such. Because massage/ bodywork should not be performed under certain medical conditions, I affirm that I have stated all my known medical conditions and answered all questions honestly. I agree to keep the practitioner updated as to any changes in my medical profile and understand that there shall be no liability on the practitioner's part should I fail to do so. I also understand that any illicit or sexually suggestive remarks or advances made by me will result in immediate termination of the session, and I will be liable for payment of the scheduled appointment. I understand it is my responsibility to cancel 24 hours in advance to avoid paying a cancellation fee.

Client Signature _____ **Date**_____

Practitioner Signature _____ **Date**_____