Medical History Form

Name_____ Email Address _____
Home phone_____ Work phone_____ Other Phone_____
Address_____ City_____ State_____ Zip_____
Date of Birth _____ Age_____ Occupation _____ Referred by_____
Primary Doctor_____ Alternative Care_____
Have you ever received a professional massage Y / N If yes, the frequency_____ Last Time _____

Do you have a history of the following:

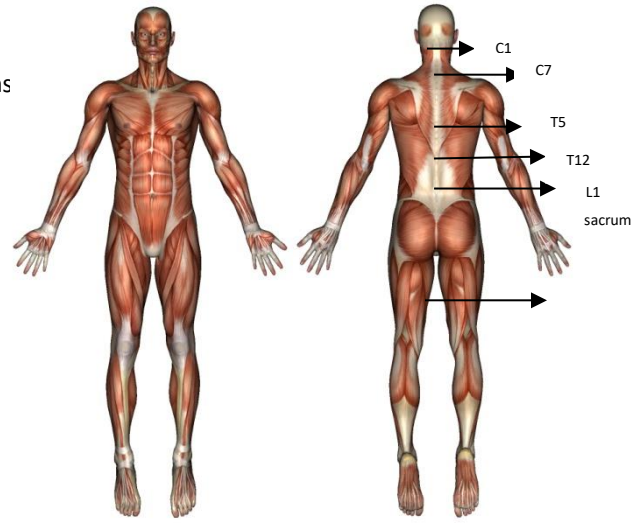
- ☐ Headaches
- ☐ Neck pain
- ☐ Shoulder/arm pain
- ☐ Mid-back pain
- ☐ Low-back pain
- ☐ Abdominal pain
- ☐ Hip/leg pain
- ☐ Spasms/cramps
- ☐ Numbness/tingling
- ☐ Joint ache
- ☐ Sprains
- ☐ Seizures
- ☐ Disk problems
- ☐ Whiplash
- ☐ Broken bones
- ☐ Surgery
- ☐ High blood pressure
- ☐ Heart attack
- ☐ Stroke
- ☐ Varicose veins
- ☐ Blood clots
- ☐ Breathing difficulty
- ☐ Less range of motion
- ☐ Jaw pain/TMJ
- ☐ Fibromyalgia
- ☐ Diabetes
- ☐ Nervous tension
- ☐ Allergies to oils
- ☐ Skin allergies
- ☐ Wear contacts
- ☐ Cancer
- ☐ Arthritis/bursitis

Please indicate daily consumption of:

	None	light	mod	hvy
Salt	☐	☐	☐	☐
Sugar	☐	☐	☐	☐
Caffeine	☐	☐	☐	☐
Tobacco	☐	☐	☐	☐
Alcohol	☐	☐	☐	☐
Exercise	☐	☐	☐	☐
water	☐	☐	☐	☐

Do you have any of these conditions today or recently:

- ☐ Headaches
- ☐ Inflammation
- ☐ Severe pain
- ☐ Pregnancy
- ☐ Sunburn
- ☐ Irritated skin rash
- ☐ Poison ivy
- ☐ Open cuts, bruises, burns
- ☐ Cold/flu
- ☐ Nausea



Other conditions that would be helpful for me to know about?

_____

Are you taking any medications? If so, for what reason?

_____

Indicated areas of your body that you **DO NOT** want worked:

- ☐ back ☐ neck
- ☐ legs ☐ chest
- ☐ buttocks ☐ Head
- ☐ arms ☐ face
- ☐ abdomen ☐ feet

What results do you want from your massage session?

_____

Please read and sign waiver:

I understand the services offered are not a substitute for medical care and that any information proved by the therapist is for educational purposes only and is not diagnostic or prescriptive in nature. The Massage Therapist reserves the right to refuse service to anyone for inappropriate behavior, illness/condition listed as contraindications for massage. I assume no responsibility for any lost, or any damages incurred to property while in the clinic, any disclosed or undisclosed illness or personal injury. I will inform my therapist of any new conditions or illnesses at any time one may occur. I will update my form yearly to ensure all information stays current so my massage therapist can give me the best treatment with the proper knowledge. The massage therapist may require documentation provided by a medical doctor before continuing further treatment.

I have read the above statements and I understand the conditions.

_____ _____

Client Signature **DATE**