



Personal Health Information

Name: _____

Email: _____

Address: _____

Preferred Contact Method: _____

City/State/Zip: _____

Date of Birth: _____

Phone: _____

Referred by: _____

Emergency contact: _____

Relation: _____ Phone: _____

Body Work History

Have you received professional massage before? _____ What frequency? _____ Date of last massage: _____

What did you like or dislike about previous massages? _____

Are you comfortable letting your therapist know if you have concerns about pressure, temperature, or anything else during your session? _____

What is your major reason for seeking massage therapy? _____

Please circle all areas of the body which you give permission to receive massage:

Back Legs Feet Buttocks Arms Hands Abdomen Upper chest Neck Head Face

Personal Health Habits

What is your occupation? _____

What do you do when you are stressed? _____

What do you do for exercise? _____

Medical History

Primary health care provider: _____ Phone: _____

Other practitioners regularly visited: _____

Permission to consult with these individuals? _____

Please list all medications and the reason for taking them: _____

Please list (date & description) any accidents or operations: _____

Please check any conditions which apply:

Musculoskeletal

- Bone or joint disease
- fractured/broken bones
- sprains/strains
- spasm/cramps
- arthritis
- back/hip/leg pain
- neck/shoulder/arm pain
- jaw pain
- other

Other

- cancer/tumors
- diabetes
- depression
- substance abuse
- anxiety/panic attacks
- insomnia
- lupus
- are you pregnant?

Circulatory

- high or low blood pressure
- varicose veins
- history of blood clots
- dizziness/fainting
- asthma
- sinus problems
- difficulty breathing
- lymphedema
- other

Digestive

- Irritable Bowel syndrome
- constipation or diarrhea
- diverticulitis
- indigestion
- hepatitis
- other

Skin

- rashes
- athlete's foot
- warts
- allergies
- other

Nervous System

- fibromyalgia
- multiple sclerosis
- herpes/shingles
- Parkinson's disease
- headaches
- areas of numbness/tingling
- stroke
- other

It is my choice to receive massage therapy and I understand that the treatment is given for the well-being of my body and mind. This includes stress reduction, relief from muscular tension, spasm or pain, and increasing circulation and energy flow. I agree that I will communicate with my practitioner if I feel like my well-being is being compromised.

In the case of hot stone massage, I understand that stones warmed to 120 degrees Fahrenheit will be in direct contact with my skin during this treatment. I will communicate directly with my provider throughout my massage about my temperature comfort level.

I understand that massage practitioners do not diagnose illness/disease or prescribe medical treatments, pharmaceuticals or perform spinal thrust manipulations. I acknowledge that massage is not a substitute for medical examination and diagnosis, and it is recommended that I see my primary care provider for that service.

I have provided accurate information on this form and will update my practitioner of any changes in my health status.

Signature: _____

Date: _____