PERSONAL HEALTH INFORMATION
MASSAGE THERAPY

Name:_________________________Date:________________Referred By:_____________________

Address:____Phone-Day:_____________________

City/State/Zip:_______________________________________Phone-Eve:______________________

Birthday:__________Emergency Contact:_____________________Phone:______________________

Primary Health Care Provider:______________________________Phone:______________________

Permission to consult with primary provider? Please initial if yes: ______________Yes

What results do you want from your massage therapy sessions? Areas to focus on? ________________
____
____

Please check the areas of your body that you give permission to receive massage:

__ back __legs __feet __arms __hands __abdomen __neck __head __face __buttocks __upper chest

Please list current medications, including aspirin, ibuprofen, etc: ______________________________
____
____

Surgeries (include year and treatment received): ____
____
____

Accidents (include year and treatment received): ____
____
____

Any topical skin allergies or food sensitivities? ____
____
____

Statement Regarding Topical Applications: "I understand that during my massage treatment, I may choose to have lotions, oils, essential oils for aromatherapy, heated stones, and/or hot towels applied to my skin. I understand that although rare, I may have an undesirable reaction to these applications. I understand what ingredients are being applied to my skin and have made my practitioner aware of any known sensitivities or allergies. I agree to communicate with my practitioner if I notice any undesirable effects during and/or after the treatment." **Please initial** : _________________________

HEALTH HISTORY

MUSCULO-SKELETAL

_____bone or joint disease___________________________
_____tendonitis/bursitis_____________________________
_____back pain_____________________________________
_____broken/fractured bones_________________________
_____arthritis______________________________________
_____lupus____
_____sprains/strains_________________________________
_____neck, shoulder, arm pain_______________________
_____headaches/head injuries________________________
_____spasms/cramps________________________________
_____jaw pain/TMJ_________________________________
_____other____

CIRCULATORY

_____heart condition________________________________
_____varicose veins_________________________________
_____blood clots____________________________________
_____high blood pressure_____________________________
_____low blood pressure_____________________________
_____lymphedema___________________________________
_____breathing difficulty____________________________
_____sinus problems_________________________________
_____allergies______________________________________
_____other____

INFECTIOUS DISEASE

____disease name(s):_________________________________
____

SKIN

_____hives______________________
_____rashes_____________________
_____eczema____________________
_____rosacea____________________
_____psoriasis__________________
_____other______________________

NERVOUS SYSTEM

_____herpes/shingles_____________
_____numbness/tingling__________
_____chronic pain_______________
_____fatigue____________________
_____sleep disorders_____________
_____other______________________

REPRODUCTIVE

_____pregnant? Stage____________
_____PMS_______________________
_____other______________________

OTHER

_____cancer/tumors______________
_____diabetes___________________
_____other______________________

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 if at 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 therapy is not a substitute for medical examination or diagnosis, and that it is recommended 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:____________________