Massage Client Medical History and Health Information

Demographics

Name: _____ Date: _____

Address: _____

City: _____State: _____Zip:_____

Email: _____

Home Phone: _____ Work Phone:_____Marital Status:_____

Date of Birth: _____ Occupation: _____Referred By: _____

Health History – Why do I need to complete this health history form? I only want a massage……

Massage therapy is intimately involved with and affects many of your body's systems. Therefore, massage may be contraindicated for people with certain medical conditions. For your maximum benefit and safety, please take the time to carefully complete this form.

Have you ever had a surgery or hospitalization? _____
_____
_____

Have you ever been involved in an injury or accident? _____
_____
_____

Do you have any chronic, ongoing conditions that you deal with on a regular basis? _____
_____
_____

Are you taking any medications? _____
_____

Are you currently seeing a doctor for any reason? _____
_____

Do you have any skin rashes or other skin problems right now? _____

Have you ever had a massage? _____

Do you have any concerns or questions about massage? What are your expectations? _____
_____
_____
_____

Please Circle all applicable issues

Skin
Fungal Infections
Herpes Simplex
Warts
Eczema
Psoriasis
Rashes
Hives
Acne
Athlete's Foot
Birthmarks
Skin Cancer

Circulatory
Anemia
Deep Vein Thrombosis
High Blood Pressure
Heart Disease/Coumadin
Varicose Veins
Clotting Disorders
Congestive Heart Failure
High Cholesterol

Endocrine
Diabetes
Hypothyroid
Hyperthyroid

Digestive
Acid Reflux
Ulcers
Crohn's Disease
Diverticulitis
Irritable Bowel Syn.
Gallstones
Hepatitis

Reproductive
Breast Cancer
Endometriosis
Ovarian Cysts
PMS
Pelvic Inflammatory
Are you pregnant?

Respiratory
Asthma
Emphysema
Sinus Problems
Tuberculosis
Lung Cancer
COPD

Musculoskeletal
Scoliosis
Fibromyalgia
Rheumatoid Arthritis
Osteoarthritis
Osteoporosis
TMJ (Jaw pain)
Sprain/Strain/Tendonitis
Carpal Tunnel Syndrome
Thoracic Outlet Syn.
Muscle Spasms
Other Inflammatory

Immune Disorders
Edema
Leukemia/Lymphoma
HIV/AIDS
Chronic Fatigue Synd.
Lupus
Other Auto-Immune

Urinary
Kidney Stones
Renal Failure
Prostate Cancer
Enlarged Prostate

Nervous
Epilepsy
Parkinson's Disease
Dementia
Multiple Sclerosis
Post Polio Syndrome
Headaches/Migraines
Stroke
Seizure Disorder
Altered Sensation
Sleep Disorders
Numbness/Tingling
Nerve Injury

Allergies
Medication_____
Food_____
Other _____

Other
Prosthetics
Implant
Contact Lenses
Piercing
Cancer
Infectious Disease
Disabilities
Fever
Lyme Disease

Please take a moment to carefully read the following information and sign where indicated.

If you have a specific medical condition or specific symptoms, massage work may be contraindicated. A referral from your primary care provider may be required prior to any bodywork.

I understand that massage therapy is not to be considered as a substitute for regular medical examination and treatment by a qualified medical professional. I understand that massage therapists are not qualified to diagnose, prescribe or treat any illness or perform spinal or skeletal adjustments. I 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.

Signature:_____Date:_____