Health History

Name _____ Phone _____ ☐ CELL ☐ LANDLINE

Email _____ Date of birth _____ Occupation _____

Address _____

Have you had massage before? ☐ YES ☐ NO

If you were referred, by whom? _____

Name and city of your doctor _____

If you are being treated by another health care professional, for what? _____

List any medications you're taking: _____

If you've had surgeries, when and for what?_____

If you've had significant injuries, when and what? _____

Why do you seek massage today — do you have a "primary complaint"? _____

_____

Check any that apply to you:	YES		YES
Respiratory condition or asthma	☐	Cancer	☐
Cardiovascular disease	☐	Arthritis	☐
High or low blood pressure	☐	Epilepsy	☐
Vision or hearing loss	☐	Diabetes	☐
Artificial joints, plates, pins	☐	Headaches	☐
Infectious condition	☐	Skin condition	☐
Currently or recently pregnant	☐	Joint discomfort	☐

Other medical conditions? _____

Are you allergic to any lotions, scents, or nut oils? _____

Please inform me of any changes to your health that might be relevant to massage, so I can provide the most effective treatment. The above information is required by law. Nothing will be shared without your consent. Feel free to ask any questions. By signing below, you confirm that it is correct to the best of your knowledge, and you have told me about any conditions that may be relevant to your treatment.

Signature _____ Date _____

As part of the treatment plan discussed with the therapist, I consent to inclusion of the following areas (please initial):

_____ pelvis, posterior / gluteals _____ pelvis, lower medial / adductors _____ ribcage, anterior / pectorals