PERSONAL HEALTH INFORMATION FOR MASSAGE THERAPY

PERSONAL DATA

Name:_____ Date:_____ Referred by:_____
Address:_____ Phone: Home_____ Cell_____
City/State/Zip_____ Birthday:_____ Occupation:_____
Emergency Contact:_____ Relationship_____ Phone:_____

MASSAGE HISTORY/TREATMENT INFORMATION

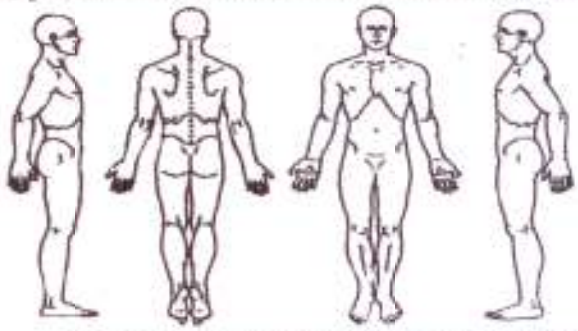
HAVE YOU EVER RECEIVED A PROFESSIONAL MASSAGE? ____ If yes, frequency _____ Date of last massage_____

CHECK RESULTS YOU WOULD LIKE TO RECEIVE FROM YOUR MASSAGE SESSION(S). **Relaxation**_____
Stress Reduction_____ If so, what is your level of stress: Low _____ Moderate _____ Extreme_____
Treatment for Specific Pain or Injury_____

How often do you experience these symptoms?
Constantly_____
Frequently_____
Occasionally_____
Intermittently_____

Describe the nature of these symptoms.
Sharp_____ Shooting_____
Dull Ache_____ Burning_____
Numbness_____ Tingling_____

If so, please indicate location of pain or symptoms.



How long have you experienced these symptoms?_____ **Indicate Intensity of pain on scale below.**

1_____5_____10
Light Moderate Severe

Think about what activities/movements make these symptoms worsen and what activities/movements improve these symptoms. Please be prepared to discuss these activities/movements with your therapist.

List all medications you currently take:_____
_____
List all previous surgeries:_____
_____
List all previous accidents:_____
_____

Health Conditions: (If you have experienced any condition below, please mark **C-for Current/P-for Past)**

____Addiction-Drug/Alcohol	____Addiction-Nicotine/Caffeine	____Allergies	____Arthritis-Osteo
____Arthritis-Rheumatoid	____Athlete's Foot	____Blood Clots	____Blood Pressure-High
____Blood Pressure-Low	____Breathing Difficulties	____Broken Bones	____Bursitis
____Cancer/Tumors	____Carpal Tunnel	____Chronic Fatique	____Chronic Pain
____Constipation	____Depression	____Diabetes	____Diverticulitis
____Eating Disorders	____Fibromyalgia	____Gas/Bloating	____Headaches
____Heart Condition	____Herpes/Shingles	____HIV/AIDS	____Irritable Bowel Synd.
____Jaw Pain/TMJ	____Joint Swelling/Stiffness	____Lymphedema	____PMS
____Pregnancy	____Seizures	____Sinus Problems	____Skin Rashes
____Sleep Disorders	____Spasms/Cramps	____Sprains/Strains	____Tendonitis
____Varicose Veins	____Warts	____Other- Please List_____	

_____
_____

Massage Therapists do not diagnose medical conditions, prescribe medications or perform spinal thrust manipulations. Please consult your primary health provider or chiropractor for these services. Your signature below verifies all medical conditions that you are aware of have been stated and that you will update the massage therapist of any changes in health status.
Signature:_____ **Date:**_____