Massage Health History

Date_____

Name _____ DOB_____

Address_____ City/State/Zip_____

Phone_____ Email_____

Occupation_____ Referred By_____

Emergency Contact Name & Number _____

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The following information will be used to help design your massage sessions.

Is this your first professional massage?_____If no, how frequently do you receive massage?_____

What are your goals for receiving massage?_____

Where in your body do you feel most alive and healthy?_____

Are you aware of holding tension in your body?___ Please explain where & when_____

Do you have allergies to oils/scents?_____ Do you have difficulty lying on your front/back/side?_____

Do you experience excess stress in your work, family, or other aspects of your life? _____

If yes, how do you think it affects your well-being? _____

How do you alleviate stress?_____

What give you the most joy in life?_____

Do you have chronic pain?_____ Please describe_____

What activities or events make it worse?_____

Are you receiving medical care for any other health issues, if yes explain?

_____

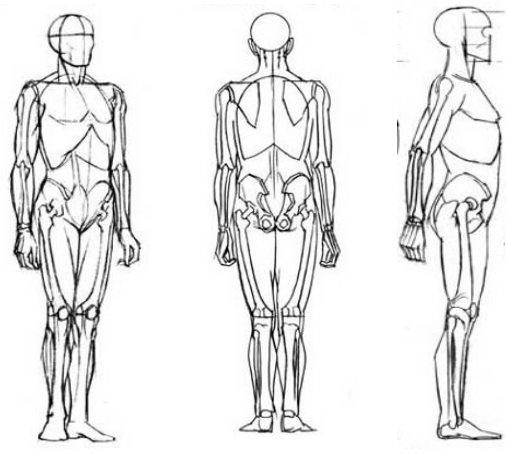
Healthcare Provider(s):_____

Current Medications/Supplements:_____

Past Surgeries & Injuries:_____

Past MVA (motor vehicle accidents)_____

Please indicate the location of your symptoms on the drawings.



Indicate which side or sides you are experiencing symptoms.

R L both

Please Check Any of the following conditions that apply to you (past/present)

Musculoskeletal System

___ Fibromyalgia
___ Spasms/Cramps
___ Sprains/Strains
___ Osteoporosis
___ Scoliosis
___ Osteo/Rheumatoid Arthritis
___ TMJ
___ Bursitis
___ Tendonitis
___ Whiplash
___ Plantar Fasciitis
___ Carpal Tunnel Syndrome
___ Sciatica
___ Headache/Migraine
___ Back/Neck Pain
___ Knee/Hip Pain
___Herniated/Bulging Disc
___ Other_____

Respiratory System

___ Asthma
___ Trouble Breathing
___ Chronic Sinus Infection
___ Other

Circulatory System

___ Anemia
___ Low/High Blood Pressure
___ Reynaud's Disease
___ Varicose Veins
___ Blood Clots/Phlebitis
___ Diabetes

Digestive System

___ IBS
___ Crohn's Disease
___ Colitis
___ Ulcers
___ Acid Reflux
___ Gas/Bloating
___ Diarrhea
___ Constipation
___ Indigestions
___ Gallstones
___ Hernia
___ Other _____

Integumentary (skin) System

___ Fungal Infection
___ Acne
___ Eczema
___ Allergy
___ Psoriasis
___ Open Wound/Sore
___ Unexplained Rash
___ Athletes Foot
___ Other_____

Nervous System

___ Multiple Sclerosis
___ Parkinson's Disease
___ Neuritis
___ Stroke
___ Numbness/Tingling/Twitching
___ Other_____

Reproductive System

___ Pregnancy's
___ PMS
___ Infertility
___ Miscarriage
___ Cesarean
___ Endometriosis
___ Irregular Cycles
___ Other _____

General

(if you answer yes to the following, please provide a brief explanation of how this presents in your life)

___ Insomnia
_____

___ Anxiety/Depression
_____

___ Stress
_____

___ Chronic Fatigue
_____

___ Cancer
_____

___ Diabetes
_____

___ Fibromyalgia
_____

If you'd like, please explain any of the above conditions or share any additional symptoms and/or health concerns below

_____
_____
_____
_____
_____
_____
_____

Preparing For Your Appointment

- If you are experiencing symptoms of sickness (fever or flu-like symptoms, infectious disease, undiagnosed skin rashes) please reschedule your appointment. In the best interest of everyone – yourself and others who will be in my treatment room that day—allow yourself to stay home and take it easy. Please be advised, if you arrive with an illness, you may be asked to reschedule.
- Please refrain from wearing cologne, fragrances, or scented products to your massage appointment as other clients may have allergies to some scents.
- Massage releases toxins in the body, so it's an excellent idea to get plenty of fluids the 24 hours leading up to your massage.

What to expect

The following sometimes occurs during a massage. These are normal responses to relaxation. Trust your body to express what it needs to.

Needing to move or change positions
Sighing/yawning, changes in breathing patterns
Stomach gurgling
Emotional feelings and/or expressions
Energy shifts
Falling asleep
Memories

Massage Therapy Informed Consent

I, _____(print name) understand that the massage I receive is provided for the basic purpose agreed upon prior to treatment. If I experience any pain or discomfort during this session, I will immediately inform the therapist so that the pressure and/or treatment plan may be adjusted to my level of comfort. I further understand that massage should not be construed as a substitute for medical examination, diagnosis, or treatment and that I should see a physician, chiropractor or other qualified medical specialist for any mental or physical ailment that I am aware of. I understand that massage therapist are not qualified to perform spinal or skeletal adjustments, diagnose, prescribe, or treat any physical or mental illness, and that nothing said in the course of the session given should be construed as such. Because massage should not be performed under certain medical conditions, I affirm that I have stated all my known medical conditions, and answered all questions honestly. I agree to keep the therapist updated as to any changes in my medical profile and understand that there shall be no liability on the therapist's part should I fail to do so.

Signature of Client_____ Date _____

Signature of Therapist_____ Date _____

Cancellation Policy

It is my policy that if you need to cancel an appointment that you call me with 24-hour notice so that I have the opportunity to offer the appointment to another client. If you do not attend a scheduled appointment or cancel an appointment with less than 24-hour notice, you are responsible for the entire charge for that visit. Exceptions for illness and/or emergencies will be taken into consideration.

Signature of Client_____ Date_____