PERSONAL HEALTH INFORMATION

PERSONAL DATA

Name: _____ Date: _____

Address: _____ Phone (day): _____

City/State/Zip: _____ Phone (eve): _____

Email: _____ Date of birth: _____

Physician: _____ Phone: _____

May we have permission to consult with your physician? Please initial if Yes _____

Emergency contact: _____ Phone: _____

MASSAGE HISTORY INFORMATION

Have you ever had a professional massage? _____Yes _____No Date of last massage _____

Is there anything you liked or disliked from previous massages? _____

Preferred massage lubricant product: ____ Lotion ____ Oil _____ Allergies?

What results would you like from your massage session? _____

_____

Please check the areas of your body that you give permission to receive massage:
____ back ____ arms ____ legs ____ neck ____ face ____ buttocks ____ abdomen ____ chest

CURRENT HEALTH TREATMENTS and PRACTICES

Are you currently seeing a medical or other health care practitioner? Please explain if Yes: _____

_____

_____

Please list your current medications, including prescriptions, aspirin, herbs and supplements: _____

_____

_____

Do you attend support group meetings or see a counselor? Please explain if Yes.

_____

Do you exercise or practice stress reduction actitivities? Include frequency. _____

_____

_____

PREVIOUS MEDICAL HISTORY

If you are or have been affected by any of the following, please comment in the space provided. Indicate whether it a past or present condition:

- Cardiovascular conditions (such as high blood pressure, angina, or stroke):
- Cancer, including the location:
- Liver or kidney conditions:
- Respiratory or lung conditions (such as emphysema or asthma):
- Diabetes:
- Injuries (including accidents):
- Bone or joint conditions (such as arthritis or osteoporosis):
- Digestive conditions (such as IBS, constipation or diarrhea):

- Autoimmune conditions (such as lupus, chronic fatigue or fibromyalgia):

- Other

TREATMENT HISTORY

Surgeries (please include the year): _____

_____

_____

Were lymph nodes removed? _____ Yes _____ No ____ Don't know

Procedures (please include the year): _____

_____

Please list any other treatments that you have undergone, including the dates:

_____

_____

_____

Consent statement:

It is my choice to receive massage. I realize that the session is being given for the purposes of relaxation and comfort only. I agree to communicate with the therapist(s) any time I feel that my well-being is being compromised.

I understand that massage therapists do not diagnose, prescribe for or treat medical conditions. I acknowledge that massage is not a substitute for medical examination or diagnosis. I have listed all medical conditions that I am aware of.

I am aware that is it in my best interest to notify my doctor that I am receiving comfort-oriented massage in case she or he wants to provide guidance.

SIGNATURE _____ DATE _____