CONFIDENTIAL HEALTH INFORMATION

Please Print Clearly

Name _____ Date _____ Referred by _____

Address _____ Phone: Home _____ Work _____

City _____ State _____ Zip _____ Date of Birth _____

Occupation _____ Employer _____

Emergency Contact Name & Telephone: _____

Are you currently seeing a medical or other health care practitioner? ☐Yes ☐No If yes, explain _____

_____

Primary health care provider _____ Phone _____

Do you give permission to consult with your primary provider? ☐Yes ☐No Do you wear contact lenses? ☐Yes ☐No

CURRENT HEALTH STATUS

Describe and prioritize symptoms: Primary ① _____

_____

Secondary ② _____ Additional ③ _____

What caused the symptoms? _____

When did you first notice symptoms? _____

On a scale of 1-10 (1 = low, 10 = high), how severe are the symptoms in each area? _____

_____

What aggravates the symptoms? _____

What relieves the symptoms? _____

Symptoms are ☐ getting worse ☐ constant ☐ intermittent ☐ increase with activity ☐ decrease with activity ☐ Disabling

Do the symptoms interfere with ☐ Work? ☐ Sleep? ☐ Daily Activities? ☐ Family/Social Relations?

Has there been a medical diagnosis of your condition? ☐Yes ☐No If yes, what was the diagnosis? _____

_____ Who made the diagnosis? _____

List current medications including pain relievers _____

_____

MASSAGE THERAPY HISTORY & INFORMATION

Have you ever received massage? ☐Yes ☐No If yes, what type and how often? _____

_____

What results do you want from your massage therapy session? _____

_____

What areas of your body do you most want massaged? _____

Please check the areas of your body for which you give permission to receive massage: ☐ Head/Scalp ☐ Face ☐ Neck

☐ Shoulders ☐ Back ☐ Chest (not breasts) ☐ Abdomen ☐ Arms ☐ Hands ☐ Buttocks ☐ Legs ☐ Feet

List any areas of your body that you do not want touched _____

HEALTH HISTORY

Include dates, description, and treatment received

Injuries _____

Surgeries _____

Major illnesses _____

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HEALTH HISTORY CONTINUED

(Please describe checked items)

MUSCULOSKELETAL

☐ Muscle tightness, stiffness, soreness, spasms, or cramps:
☐ Jaw ☐ Neck ☐ Back ☐ Buttocks ☐ Legs
☐ Feet ☐ Arms ☐ Hands ☐ Shoulders ☐ Chest

☐ Muscle strains _____
☐ Joint sprain/dislocations _____
☐ Bone or joint disease _____
☐ Broken bones _____
☐ Arthritis _____
☐ Headaches _____
☐ Tendonitis/tendinosus _____
☐ Bursitis _____
☐ Herniated disc _____
☐ Osteoporosis _____
☐ Lupus _____
☐ TMJ _____
☐ Other _____

CARDIOVASCULAR

☐ Heart conditions _____
☐ Recent heart attack or stroke _____
☐ Varicose veins _____
☐ Phlebitis _____
☐ Blood clots _____
☐ High unstable blood pressure _____
☐ Aneurysm _____
☐ Hemophilia _____
☐ Arteritis _____
☐ Other _____

INFECTIOUS DISEASE

☐ Disease name(s) _____
_____

SKIN & NAILS

☐ Allergies _____
☐ Rashes _____
☐ Warts _____
☐ Fungus _____
☐ Other _____

DIGESTIVE

☐ Constipation _____
☐ Diverticular disease _____
☐ Gastroenteritis _____
☐ Other _____

NERVOUS SYSTEM

☐ Herpes/shingles _____
☐ Numbness/tingling _____
☐ Acute neuritis _____
☐ Other _____

REPRODUCTIVE

☐ Pregnancy - Stage _____
☐ PMS _____
☐ Other _____

OTHER

☐ Depression _____
☐ Anxiety _____
☐ Cancer, type & location _____
_____
☐ Severe atherosclerosis _____
☐ Fever _____
☐ Open wounds or sores _____
☐ Advanced disease of kidney, liver, lungs _____
_____
☐ Diabetes _____
☐ Acute inflammation (pain, heat, redness, swelling) _____
_____
☐ Please list any other conditions/symptoms/allergies _____
_____
_____
☐ Medical implants, such as stents or pacemakers, and their locations _____

LIFESTYLE

	Heavy	Moderate	Light
☐ Alcohol	___	___	___
☐ Fast Food	___	___	___
☐ Soft Drinks	___	___	___
☐ Caffeine	___	___	___
☐ Tobacco	___	___	___
☐ Exercise	___	___	___

Type and frequency of exercise _____
_____
_____

Overall level of stress: ☐ Low ☐ Medium ☐ High

What do you do to relieve stress? _____
_____
_____
_____

Is there anything else you want to discuss with me? _____
_____

The above information is accurate to the best of my knowledge. I have indicated all medical conditions of which I am aware and will not hold you responsible for the aggravation of conditions that were not disclosed to you at the time of the massage and that may be affected by the massage. I will keep you informed about any changes in my health and I will not hold you responsible should I forget to do so. I understand that massage therapy services are not licensed by the state and are not a substitute for medical examination, diagnosis or treatment. I agree to tell you if I feel that my emotional or physical well-being is being compromised. I agree to give you 24 hours notice should I have to cancel or reschedule an appointment.

I understand that this information is confidential and will be viewed only by the massage therapy students who provide my massage, and by the students' instructors.

Signature _____ Date _____