Health History

Mark any of the following conditions you are experiencing, or have experienced in the past

Headaches  Heart Issues/Circulatory Problems 

Neck and/or Shoulder Issues  Varicose Veins 

Arm/Wrist/Hand Issues  Sinus Problems/Allergies 

Mid-Back Issues  Respiratory Problems/Asthma 

Lower Back/Side/Hip Issues  Skin Irritations/Conditions 

Legs/Ankles/Feet issues  Digestive Issues 

Joints/Range-of-Motion Issues  Autoimmune Disorders 

TMJ Disorder (Teeth/Jaw Problems)  Sleep Problems/Insomnia 

Arthritis  Cancer (ask for Oncology Form) 

Blood Pressure ( High  Low) Anxiety/Depression 

Allergies \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Do you have any other medical problems not listed above? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

List any surgeries, accidents, or injuries you have had in the last 2 years: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

List any medications (Prescribed or self-prescribed), and for which conditions: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Please list the name, address and phone number of your primary care physician (if applicable): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

***May we contact your primary care physician if we have questions about any of your diagnosed conditions? Yes No***

Personal Information

Legal Name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Today’s Date \_\_\_\_\_\_\_\_\_\_\_\_\_

Preferred Name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Birthday \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

City \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ State \_\_\_\_\_\_\_ Zip \_\_\_\_\_\_\_\_

Phone \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Email \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Preferred contact:  Phone Text  Email

Gender (circle one) Male Female Prefer not to say

Occupation \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

In the event of an emergency, whom should we contact?

Name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Relationship\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

I understand that bodywork given here is for the purpose of relaxation, relieffor muscular tension or spasm, or for improving circulation and energy flow. I understand that my practitioner does not diagnose illness, disease, or any other physical or mental disorder. As much, my practitioner does not prescribe medical treatment or pharmaceuticals, nor does my practitioner perform spinal manipulations. It has been made very clear to me that bodywork is not a substitute for medical examinations and/or diagnosis, and it is recommended that I see a physician for any physical ailment that I might have. Because my practitioner must be aware of existing physical conditions, I have stated all my known medical limitations and take it upon myself to keep my practitioner updated on my physical health.

Massage Experience

Have you ever had a Professional Massage Before Yes No

If so, how long ago/ how often \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

What type of pressure do you prefer? (circle)

Light Medium Firm Deep Tissue

Are there areas that you would like more focus on? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Are there any areas you DO NOT want worked on? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

What kind of sounds help you to relax? (circle all that apply)

 Soothing Music Classical Music Nature Sounds Other

If Other please explain \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Of our enhancements are there any that you would be interested in for future appointments? Mark all that apply

Aromatherapy  Aroma-Scalp Massage  Mini Hot Stone 

Cold Stone Face  Hand OR Foot Scrub 

\*Ask about Aromatherapy List for different options for aromatherapy/aroma-scalp

Client Signature \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date \_\_\_\_\_\_\_\_\_\_

Parent or Guardian (if client is under 18) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Therapist Signature \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_