



Massage Therapy Health History Form

Name: _____ Date: _____

Date of Birth: _____ Gender: M__ F__ Phone #: _____

Address: _____

Emergency Name and Phone #: _____

Occupation: _____ Bus. Phone #: _____

Referred by: _____ Appointment Reminder: Phone __ Text __

Clinical Data:

What is your reasoning for receiving a massage? _____

Present injury/Problem: _____

Started when/how? _____

What actions create the pain? _____

Does the pain radiate? _____ Where? _____

Do you have any past injuries? _____

Please Check Off Those Applicable:

1. Cardiovascular

- High/Low Blood Pressure
- Stroke
- Varicose Veins
- Cold hands/feet

2. Respiratory

- Asthma
- Shortness of Breath
- Smoking
- Chronic cough

3. Digestive System

- Heartburn
- Constipation
- Nausea
- Excessive Gas

4. Muscle/ Joints

- Pain
- Stiffness
- Limitation of movement
- Arthritis

5. Head

- Headaches
- Vision problems
- Deafness
- Clenching/Grinding teeth

6. Reproductive System

- Pregnant; Due date: _____
- Fibroids
- Severe cramping

7. Urinary System

- Kidneys
- Bladder

8. Skin

- Sensitive skin
- Rashes/Eczema
- Bruise easily

9. Nerves

- Sciatica
- Numbness
- Tingling

10. Other

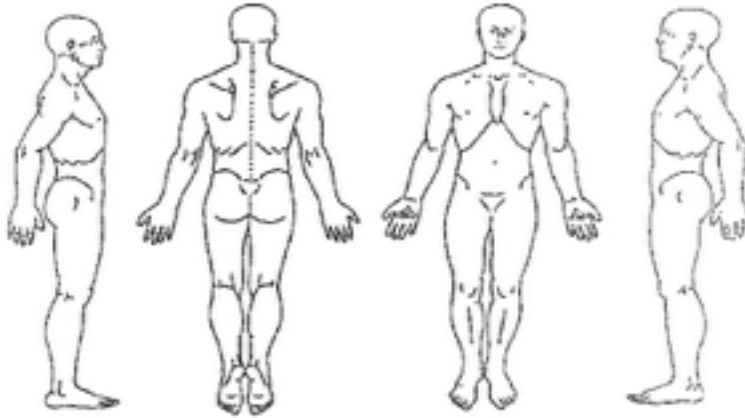
- Diabetes
- Allergies
- Cancer
- Epilepsy

11. Medical

- Surgery
- Accidents
- Injuries

Pain Chart

Please indicate the areas you have pain and the level of the pain on a scale of 1-10.
(1 being little or no pain, 10 being the highest level)



Please list any current Medications/Drugs/Vitamins you are taking:

The information I have provided is correct to the best of my knowledge. I will update my massage therapist of any changes in my health if they occur. I understand that a massage therapist neither diagnosis illness, disease nor any other medical, physical or mental disorders nor performs any spinal manipulations. I understand that any remarks or actions of a sexual or personal nature will result in immediate termination of session and that no future appointments will be allowed. I understand that this information will be kept confidential unless I give my written consent. I have carefully read and understand all of the above.

Signature

Date

Print Name

(Parent or Guardian Signature if under 18 years of age)