CONFIDENTIAL HEALTH INFORMATION

Please Print Clearly

Name ______________________________ Date ___/___/______ Referred by ______________________

Address ______________________________ Home Phone ______________ Work Phone ______________

City ______________________ State _____ Zip __________ Date of Birth ___/___/______ □ Male □ Female

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 your current state of health ______________________________

____

____

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

______________________Who made the diagnosis? ______________ Phone ______________

When did you first notice symptoms? ______________________________

What caused the symptoms? ______________________________

What aggravates the symptoms? ______________________________

Are the symptoms getting progressively worse? □ Yes □ No □ Symptoms are constant □ Symptoms come and go

Do the symptoms interfere with □ Work? □ Sleep? □ Daily Routine? □ Personal Relations?

What have you done to get relief? ______________________________

List all current medications including aspirin, ibuprofen, herbs, supplements, blood thinners, etc. ______________

____

PREVIOUS HISTORY

Have you had any accidents or injuries? □ Yes □ No If yes, give dates and describe each incident ______________

____

____

Have you had any operations? □ Yes □ No If yes, give dates and describe each incident ______________

____

____

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 areas of your body you do not want touched ______________________

⇓ **Over Please**⇓

HEALTH HISTORY

(Please describe items checked)

MUSCULOSKELETAL

- ☐ Muscle 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/tenosynovitis ______
- ☐ Bursitis ______
- ☐ Herniated disk ______
- ☐ Osteoporosis/osteomalacia/osteomyelitis ______
- ☐ Lupus ______
- ☐ TMJ ______
- ☐ Other ______

CARDIOVASCULAR

- ☐ Heart conditions ______
- ☐ Recent heart attack or stroke______
- ☐ Varicose veins ______
- ☐ Phlebitis ______
- ☐ Blood clots ______
- ☐ High unstable blood pressure ______
- ☐ Aneurysm ______
- ☐ Hemophilia ______
- ☐ Arteritis (inflammation of an artery) ______
- ☐ Other ______

INFECTIOUS DISEASE

- ☐ Disease name(s) ______

______

SKIN / NAILS

- ☐ Allergies ______
- ☐ Rashes ______
- ☐ Warts ______
- ☐ Fungus ______
- ☐ Other ______

DIGESTIVE

- ☐ Constipation ______
- ☐ Diverticulitis ______
- ☐ Other ______

NERVOUS SYSTEM

- ☐ Herpes/shingles ______
- ☐ Numbness/tingling ______
- ☐ Acute neuritis (inflammation of a nerve or nerves)

  ______
- ☐ Other ______

REPRODUCTIVE

- ☐ Pregnant - Stage ______
- ☐ PMS ______
- ☐ Other ______

OTHER

- ☐ Depression ______
- ☐ Anxiety ______
- ☐ Lymphosarcoma, malignant melanoma or other cancer ______
- ☐ 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 implant, such as a stent or pacemaker. Where is it located? ______

LIFESTYLE

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

Type and frequency of exercise ______

______

______

Hobbies ______

______

Overall level of stress: ☐ Low ☐ Medium ☐ High

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 an appointment for any reason.

I understand that this information is confidential and will be viewed only by the massage therapy student who gave me this form, and by his or her instructors.

Signature ______ Date ______