MASSAGE THERAPY MEDICAL HISTORY

Patient Name: _____

Date of Birth: _____

Occupation: _____

The following information will be used to help plan safe and effective massage sessions.

Please answer to the best of your knowledge.

1. Please check any condition listed below that applies to you:

( ) contagious skin conditions	( ) phlebitis
( ) open sores or wounds	( ) deep vein thrombosis/blood clots
( ) easy bruising	( ) epilepsy
( ) recent accident or injury	( ) headaches/migraines
( ) recent fracture	( ) cancer
( ) recent surgery	( ) diabetes
( ) artificial joint	( ) decreased sensation
( ) sprains/strains	( ) back/neck problems
( ) current fever	( ) fibromyalgia
( ) swollen glands	( ) tmj
( ) allergies/sensitivity	( ) carpal tunnel syndrome
( ) heart condition	( ) tendonitis
( ) high or low blood pressure	( ) osteoporosis
( ) circulatory	( ) arthritis
( ) varicose veins	( ) joint disorder
( ) atherosclerosis	( ) Pregnant, how many months? _____

Please explain any condition that you have marked above: _____

_____

_____

2. Have you had a professional massage before? ( ) Yes ( ) No
   If yes, how often do you receive massage therapy? _____

3. Do you have difficulty lying on your front, back or side? ( ) Yes ( ) No
   If yes, please explain _____

4. Do you have any allergies to oils, lotion or ointments? ( ) Yes ( ) No
   If yes, please explain _____

5. Do you have sensitive skin? ( ) Yes ( ) No

6. Are you wearing ( ) contact lenses ( ) dentures ( ) hearing aids?

7. Do you sit for long hours at a workstation, computer or driving? ( ) Yes ( ) No
   If yes, please explain _____

8. Do you perform any repetitive movement in your work, sports or hobbies? ( ) Yes ( ) No
   If yes, please explain _____

9. Do you experience stress in your work, family or any other aspects of your life?
( ) Yes ( ) No If yes, how do you think it affects your health? _____
( ) muscle tension ( ) anxiety ( ) Insomnia ( ) irritability ( ) Other _____

10. Is there a particular area of the body where you are experiencing tension, stiffness, pain or any other discomfort? ( ) Yes ( ) No
If yes, please Identify _____

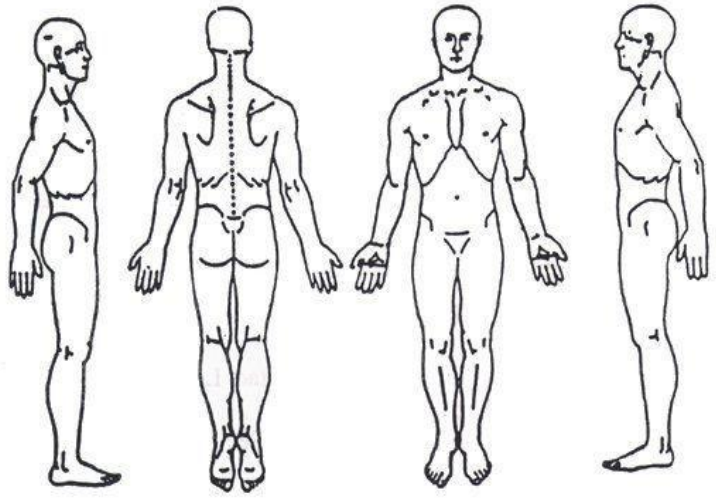
11. Do you have any particular goals in mind for this massage session? ( ) Yes ( ) No
If yes, please explain _____

12. Are you currently under medical supervision? ( ) Yes ( ) No
If yes, please explain _____

13. Do you see a chiropractor? ( ) Yes ( ) No

14. Are you currently taking any medications? ( ) Yes ( ) No
If yes, please list _____

15. Is there anything else about your health history we should know?
_____
_____



Circle areas you would like to focus on during your session.

Draping will be used during the session – only the area being worked on will be uncovered.

I acknowledge that massage therapy is not a substitute for medical care, medical examination or diagnosis. I have stated all medical conditions that I am aware of and will inform my practitioner of any changes in my health status.

Patient Signature: _____ Date: _____