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Personal Health History Information

All information within is strictly confidential.

Name _____Birth date_____

Address_____ Phone (day)_____

City/State/Zip_____Phone (home)_____

Occupation_____

Local Emergency Contact_____Phone_____

Doctor or clinic _____Phone_____

Do you give your permission to consult with doctor or clinic? Please initial. Yes _____No _____

Chiropractor_____Phone_____

Do you give your permission to consult with chiropractor? Please initial. Yes _____No _____

Treatment Information

- Is this your first professional massage? Yes _____No _____
- What is the reason for your visit? *(Please list any current symptoms.)* _____

_____
_____
_____
_____

- Are you currently seeing a medical practitioner? Yes _____No _____

If yes, for what reason?

_____
_____
_____
_____

- Are you currently seeing a chiropractor? Yes _____No _____

If yes, for what reason?

_____
_____
_____

- Have you ever suffered an injury? Yes _____No _____

If yes, please describe all injuries and include dates, diagnosis and treatment received.

_____
_____
_____
_____

- Have you ever had surgery? Yes _____No _____

If yes, please describe and include dates.

_____
_____
_____
_____

- Do you have any skin problems or allergies? Yes _____No _____

*If yes, please describe.*_____
_____
_____

- Are you HIV positive? Don't know_____Yes _____No _____
- Are you pregnant? *Due date*_____ Yes _____No _____
- Do you have varicose veins? Yes _____No _____

*If yes, please describe type and locations.*_____
_____
_____

- Do you have diabetes? Yes _____No _____

If yes, please note what type, when diagnosed and if under the care of a physician _____
_____
_____

- Have you ever been diagnosed with blood clots? Yes _____No _____

If yes, please include type, date, location, treatment received and current status. _____
_____
_____

- Have you been diagnosed with arthritis? Yes _____No _____

*If yes, please include diagnosis, treatment received, and current status.*_____
_____
_____
_____

- Do you have any heart or blood pressure problems? Yes _____No _____

If yes, please describe and include date and treatment received. _____
_____
_____
_____

▪ DO YOU EXPERIENCE:	often	occasional	currently	duration of symptom
__headaches	____	____	____	_____
__neck pain or stiffness	____	____	____	_____
__shoulder pain or restriction	____	____	____	_____
__pain between the shoulder blades	____	____	____	_____
__back pain	____	____	____	_____
__general stiffness or soreness	____	____	____	_____
__numbness/tingling in arm or hand	____	____	____	_____
__sore, stiff or aching hips	____	____	____	_____
__nerve pain down the legs	____	____	____	_____
__restricted range of motion	____	____	____	_____
__foot problems	____	____	____	_____
__pain when performing motions	____	____	____	_____
__other_____	____	____	____	_____

- *Please use this space if you wish to further explain your symptoms.*

_____
_____
_____
_____

- List all medications you take at this time, including ibuprofen, aspirin, etc., and explain the condition for which each is taken.

_____
_____
_____
_____

- List your exercise activities and frequency of activity.

_____
_____
_____
_____

- List any other medical or physical condition that has not been mentioned on this form.*(Please include dates, medications, and treatment received.)*

_____
_____
_____
_____

- *The massage therapist does not diagnose illness, disease or any other physical or mental disorder. As such, the massage therapist does not prescribe medical treatment or pharmaceuticals nor do they perform any spinal manipulations. This massage therapy is not a substitute for medical examinations and/or diagnosis.*

Because a massage therapist must be aware of existing physical conditions, I have stated all my known medical conditions and take it upon myself to keep the massage therapist updated on my physical health.

Signature _____*Date*_____