Massage Health History Form

Name ____ **Phone** (_____) ______- _________ **DOB**____/____/___

Occupation ____ **Gender** _________ _______________

*If you are **(a)** under a physician's care for any chronic/acute medical condition, **(b)** recovering from a recent injury or surgery, and/or **(c)** involved in a workman's comp or accident case, please check with your physician prior to scheduling a massage and obtain written clearance/guidance, as necessary.*

IS THIS YOUR FIRST MASSAGE EVER? □ Yes □ No **What is your goal for today's session?** _______________________

DO YOU HAVE ANY ALLERGIES? □ Yes □ No If 'Yes', please specify: ____

HISTORY: (Please check responses and make additional notes, as needed)

PREFERENCES: (Please circle or check preferences)

Pressure: Light/ Medium /Firm ***Aromatherapy***: □ Yes □ No ***Heat:*** □ Yes □ No **Medium:** Oil/Cream/Lotion

Do you frequently suffer from stress? □ Yes □ No

Do you have diabetes? □ Yes □ No

Do you experience frequent headaches? □ Yes □ No

If you have high blood pressure, are you taking high blood pressure medication? □ Yes □ No □ N/A

If 'Yes', is it well-controlled? □ Yes □ No

Do you suffer from epilepsy/seizures? □ Yes □ No

Do you suffer from arthritis? □ Yes □ No

Do you suffer from joint swelling? □ Yes □ No

Do you have varicose veins? □ Yes □ No

Do you have any contagious diseases? □ Yes □ No

Do you have osteoporosis? □ Yes □ No

Do you bruise easily? □ Yes □ No

Females: Are you pregnant? □ Yes □ No □ N/A

Any broken bones in the past two years? □ Yes □ No

If 'Yes', please explain__________________________

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Do you suffer from back pain? □ Yes □ No

Do you have numbness or stabbing pains? □ Yes □ No

Any other injuries in the past two years? □ Yes □ No

If 'Yes', please explain ______________________________

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Have you recently had surgery? □ Yes □ No If Yes, please explain___________________________________

Do you have cardiac/circulatory problems? □ Yes □ No

Are you sensitive to touch or pressure in any area?

□ Yes □ No If 'Yes', where? _________________________

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Other medical condition(s) or medications I should know about? □ Yes □ No If 'Yes', please explain:

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Do you have tension or soreness in a specific area?

□ Yes □ No If 'Yes', please specify ___________________

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NOTE: *We require 24Hr notice to schedule or cancel an appointment. Appointments canceled without 24 hour notice may be charged at the full rate.* **Client Initials:** ____________

Because massage/ bodywork should not be performed under certain medical conditions, I affirm that I have stated all my known medical conditions and answered all questions honestly. I further understand that massage or bodywork should not be construed as a substitute for medical examination, diagnosis, or treatment and that I should see a physician, chiropractor, or other qualified medical specialist for any mental or physical ailment of which I am aware. **I agree to keep the practitioner updated as to any changes in my medical profile and understand that there shall be no liability on the facility's or practitioner's part should I fail to do so.** I understand that the massage/bodywork I receive is provided for the basic purpose of relaxation and relief of muscular tension. **If I experience any pain or discomfort during this session, I will immediately inform the practitioner so that the pressure and/or strokes may be adjusted to my level of comfort.** *I also understand that any illicit or sexually suggestive remarks or advances made by me will result in immediate termination of the session, and I will be liable for payment of the scheduled appointment.*

(For Therapist: Initial after review) _____

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Client Signature **Date**