# HEALTH HISTORY FOR MASSAGE THERAPY

**NAME_____DATE_____**

**ADDRESS_____CITY_____STATE___**

**ZIP CODE _____TELEPHONE #_____CELL PHONE#_____**

**OCCUPATION_____DATE OF BIRTH_____**

**NAME OF PHYSICIAN_____TELEPHONE #_____**

**OTHER HEALTH CARE PROVIDER_____**

**HAVE YOU EVER HAD MASSAGE? YES NO**

**FOR WOMEN: ARE YOU PREGNANT? YES NO IF YES, HOW MANY MONTHS?_____**

**DO YOU HAVE ANY DIFFICULTY LYING ON YOUR FRONT, BACK OR SIDE? YES NO**

**IF YES, PLEASE EXPLAIN_____**

**DO YOU HAVE ALLERGIC REACTIONS TO OILS, LOTIONS, OINTMENTS, ETC. PUT ON YOUR SKIN? YES NO**

**DO YOU WEAR CONTACT LENSES, DENTURES, HEARING AIDS, ETC? YES NO**

**DO YOU SIT FOR LONG HOURS AT A WORKSTATION, COMPUTER, OR DRIVING? YES NO**

**PLEASE DESCRIBE_____**

**DO YOU PERFORM ANY REPETITIVE MOVEMENT IN YOUR WORK, SPORTS, OR HOBBY?**

**IF YES, PLEASE DESCRIBE_____**

**DO YOU EXPERIENCE STRESS IN YOUR WORK, FAMILY, OR OTHER ASPECT OF YOUR LIFE?**

**IF YES, PLEASE DESCRIBE_____**

**HOW WOULD YOU DESCRIBE YOUR STRESS LEVEL? LOW MEDIUM HIGH VERY HIGH**

**IF HIGH, HOW DO YOU THINK STRESS HAS AFFECTED YOUR HEALTH? MUSCLE TENSION ( )**

**ANXIETY ( ) INSOMNIA ( ) IRRITABILITY ( ) OTHER_____**

**IS THERE A PARTICULAR AREA OF THE BODY WHERE YOU ARE EXPERIENCING TENSION, STIFFNESS, OR OTHER DISCOMFORT? PLEASE DESCRIBE_____**

**IN ORDER TO PLAN A MASSAGE SESSION THAT IS SAFE AND EFFECTIVE, WE NEED SOME GENERAL INFORMATION ABOUT YOUR MEDICAL HISTORY.**

**ARE YOU CURRENTLY UNDER MEDICAL SUPERVISION? YES NO**

**ARE YOU CURRENTLY TAKING ANY MEDICATION? YES NO**

**IF YES, PLEASE LIST_____**

***PLEASE CHECK ANY CONDITION LISTED BELOW THAT APPLIES TO YOU:***

**SKIN CONDITIONS (ACNE, RASH, SKIN CANCER, ALLERGY, EASY BRUISING, CONTAGIOUS CONDITION) _____**

**ALLERGIES_____**

**RECENT ACCIDENT, INJURY, OR SURGERY (WHIPLASH, SPRAIN, BROKEN BONE. DEEP BRUISE YES NO**

**MUSCULAR PROBLEMS (TENSION, CRAMPING, CHRONIC SORENESS)_____**

**JOINT PROBLEMS (OSTEOARTHRITIS, RHEUMATOID ARTHRITIS, GOUT, RECENT DISLOCATION) YES NO**

**LYMPHATIC CONDITION (SWOLLEN GLANDS, NODES REMOVED, LYMPHOMA, LYMPH EDEMA) YES NO**

**CIRCULATORY OR BLOOD CONDITIONS (ATHEROSCLEROSIS, VARICOSE VEINS, PHLEBITIS, ARRHYTHMIAS, HIGH OR LOW BLOOD PRESSURE, HEART DISEASE, RECENT HEART ATTACK OR STROKE, ANEMIA)_____**

**NEUROLOGIC CONDITION (NUMBNESS OR TINGLING IN A NY AREA OF THE BODY, SCIATICA, DAMAGE FROM STROKE, EPILEPSY, MULTIPLE SCLEROSIS, CEREBRAL PALSY)_____**

**DIGESTIVE CONDITIONS_____**

**IMMUNE SYSTEM CONDITIONS (CHRONIC FATIGUE, HIV/AIDS) _____**

**SKELETAL CONDITIONS (OSTEOPOROSIS, BONE CANCER, SPINAL INJURY) _____**

**HEADACHES (TENSION, PMS, MIGRAINES) _____**

**CANCER_____**

**EMOTIONAL DIFFICULTIES (DEPRESSION, ANXIETY, PANIC ATTACKS, EATING DISORDER, PSYCHOTIC EPISODES) _____ARE YOU CURRENTLY SEEING A PSYCHOTHERAPIST FOR THIS CONDITION? YES NO**

**PREVIOUS SURGERY, DISEASE, OR OTHER MEDICAL CONDITION THAT MAY BE AFFECTING YOU NOW (POLIO, PREVIOUS HEART ATTACK OR STROKE, PREVIOUSLY BROKEN BONES) YES NO**

**IS THERE ANYTHING ELSE ABOUT YOUR HEALTH HISTORY THAT YOU THINK WOULD BE USEFUL FOR YOUR MASSAGE PRACTITIONER TO KNOW TO PLAN A SAFE AND EFFECTIVE MASSAGE SESSION FOR YOU?**

**IF YES, PLEASE EXPLAIN_____**

**HAS YOUR PHYSICIAN OR OTHER HEALTH CARE PROVIDER RECOMMENDED MASSAGE FOR ANY OF THE CONDITIONS LISTED ABOVE? YES NO**

**DO YOU HAVE ANY PARTICULAR GOALS IN MIND FOR THIS MASSAGE SESSION RELATED TO ANY OF THE CONDITIONS MENTIONED ABOVE?**

**IF YES, PLEASE EXPLAIN_____**

**I UNDERSTAND THAT I SHOULD SEE A DOCTOR OR OTHER APPROPRIATE HEALTH CARE PROVIDER FOR DIAGNOSIS AND TREATMENT OF ANY SUSPECTED MEDICAL PROBLEM. IT MAY BE BENEFICIAL FOR MY MASSAGE PRACTITIONER TO SPEAK TO MY DOCTOR ABOUT MY MEDICAL CONDITION TO DETERMINE HOW MASSAGE MAY HELP THE HEALING PROCESS, AND TO AVOID WORSENING THE CONDITION. I WILL BE ASKED FOR PERMISSION TO CONTACT MY DOCTOR IF THE MASSAGE PRACTITIONER THINKS THAT IT MIGHT BE USEFUL. I ALSO UNDERSTAND THAT IT IS MY RESPONSIBILITY TO KEEP MY MASSAGE PRACTITIONER INFORMED OF ANY CHANGES IN MY HEALTH, AND ANY MEDICATIONS THAT I MAY BEGIN TO TAKE IN THE FUTURE.**

**IN ORDER TO RESPECT OTHER CLIENT'S TIME, YOUR TIME BEGINS ON THE APPOINTED TIME YOU HAVE MADE AND IT WILL END AS AGREED, INCLUDING BEING LATE, CONSULTATION, AND PAPERWORK.**

**TIME IS A PRECIOUS COMMODITY. I AM COMMITTED TO PROVIDING YOU WITH THE TIME YOU DESERVE TO MEET ALL OF YOUR SERVICE NEEDS. IF YOU NEED TO RESCHEDULE YOUR APPOINTMENT, PLEASE ALLOW A MINUMUM 24-HOUR NOTICE. A *$30.00* FEE WILL BE CHARGED FOR MISSED APPOINTMENTS/APPOINTMENTS NOT CANCELLED WITHIN 24-HOUR TIME FRAME.**

**SIGNATURE_____DATE_____**

**PLEASE PROVIDE YOUR E-MAIL ADDRESS. I WILL BE SENDING E-NEWSLETTERS TO MY CLIENTS ABOUT VARIOUS TOPICS CONCERNING HEALTH AND WELLNESS.**

**_____@_____**

**Please print clearly.**