Health History

Name:	(Please check preferred method of contact)
Mailing address:	☐ Home phone:
	☐ Work phone:
Occupation:	☐ Cell phone:
Physician's name:	☐ Email:
Referred by:	Date of birth:

Do you have a particular area of pain or concern? Please briefly describe:

Medical History • I have or have had the following:

- ☐ Varicose veins
- ☐ Dizziness
- ☐ Osteoarthritis
- ☐ Rheumatoid Arthritis
- ☐ Chest pain
- ☐ Phlebitis
- ☐ Emphysema
- ☐ Loss of sensation
- ☐ Tingling in arms / legs
- ☐ Abdominal discomfort
- ☐ Cancer
- ☐ Hearing / vision loss
- ☐ HIV / AIDS
- ☐ Tuberculosis
- ☐ Anaphylactic shock
- ☐ Constipation
- ☐ Diabetes
- ☐ Hepatitis
- ☐ Asthma
- ☐ Chronic cough
- ☐ Bronchitis
- ☐ Difficulty breathing
- ☐ Epilepsy
- ☐ Multiple sclerosis
- ☐ Tuberculosis
- ☐ Skin irritation / rash
- ☐ TMJ pain/dysfunction
- ☐ Osteoporosis
- ☐ Endometriosis
- ☐ Weight gain / loss
- ☐ Loss of appetite
- ☐ Muscle weakness
- ☐ Skin condition
- ☐ Plantar's warts
- ☐ Stroke
- ☐ Heart attack
- ☐ High blood pressure
- ☐ Low blood pressure
- ☐ Hemophilia
- ☐ Chronic congestive heart failure
- ☐ I am now or may be pregnant.
- ☐ Other conditions:

I have / use the following:

- ☐ artifical limb
- ☐ eyeglasses
- ☐ contact lenses
- ☐ pacemaker
- ☐ cosmetic implant
- ☐ metal implanted
- ☐ back brace
- ☐ neck brace

☐ I am allergic to:

☐ I am currently taking these medications:
(Please indicate reasons for use.)

I understand the above information is confidential and used to help my massage therapist determine indications and contraindications for massage. I understand that massage therapy is not a replacement for medical care and no diagnosis will be made. I have truthfully detailed my previous and current health status, I agree to keep my practitioner informed of any changes in my health status and I consent to receive massage therapy treatments. I am aware twenty-four hours notice must be given before cancelling an appointment or I will be held financially accountable for the entire fee of that session. I am aware that this charge will be sent to me directly and not to my health plan.

Signature ______________________ Date: ______________