Health History Form

name _____ birth date _____

address: city/state/zip _____

phone number _____ email _____

occupation _____ date of injury (if applicable) _____

emergency contact: name and phone number _____

Have you received professional massage in the past? ◯ yes ◯ no If yes, how often? _____

Please list and explain all medications that you are currently taking, if any (including herbal remedies):

_____

Please list allergies, if any: _____

Please list any **surgeries**, **hospitalizations**, **infections**, **illnesses**, and **accidents** that you have experienced:

_____

Are you currently under the care of a healthcare professional? ◯ yes ◯ no

Please indicate and briefly explain any of the following conditions that apply to you:

Cardiovascular

◯ heart disease/condition: _____
◯ varicose veins: _____
◯ blood clots/aneurysm: _____
◯ high/low blood pressure: _____
◯ edema: _____
◯ pacemaker: _____
◯ other: _____

Musculoskeletal

◯ neck/shoulder/arm pain (circle)_____
◯ low-back/hip/leg pain (circle)_____
◯ arthritis: _____
◯ tendonitis/bursitis: _____
◯ jaw pain/TMJ: _____
◯ bone/joint disease: _____
◯ sprain/strain: _____
◯ multiple sclerosis: _____
◯ other: _____

Respiratory

◯ asthma: _____
◯ shortness of breath: _____
◯ chronic cough: _____
◯ bronchitis: _____
◯ emphysema: _____
◯ sinus irritation: _____
◯ other: _____

Skin

◯ rash: _____
◯ athletes foot: _____
◯ warts: _____
◯ other: _____

Digestive

◯ constipation: _____
◯ diarrhea: _____
◯ gas/bloating: _____
◯ abdominal pain: _____

◯ headache/head injury: _____
◯ spasms/cramps: _____
◯ pins/plates/surgical implants: _____
◯ other: _____

◯ acid reflux: _____
◯ IBS: _____
◯ celiac disease: _____
◯ other: _____

Urinary

◯ kidney failure: _____
◯ kidney stones: _____
◯ other: _____

Endocrine

◯ diabetes (type I/II): _____
◯ hyper/hypothyroidism: _____
◯ other: _____

Nervous

◯ numbness/tingling: _____
◯ seizures: _____
◯ chronic fatigue: _____
◯ sleep disorder: _____
◯ anxiety: _____
◯ depression: _____
◯ mental illness: _____

Miscellaneous

◯ vision impairment: _____
◯ hearing loss: _____
◯ history of headache/migraine: _____
◯ vertigo: _____
◯ prosthesis: _____
◯ cancer/tumor: _____
◯ infectious disease: _____

All systems: additional info: _____

_____

If you are currently pregnant or have cancer, approval from a doctor is needed in order to receive massage.

Please initial beside each statement:

____ It is my choice to receive bodywork. I realize that the treatment I receive is for the basic purpose of relaxation and/or relief of muscular tension. If I experience any **pain or discomfort** during this session, I will **immediately inform the practitioner**.

____ I understand that **the massage practitioner does not diagnose** disease, physical or emotional disorders, nor does she prescribe medical treatment, pharmaceuticals, or perform spinal manipulations. I acknowledge that massage is not a substitute for medical examination or diagnosis, and that it is recommended that I see a primary health care provider for such service.

____ I have **stated all medical conditions** that I am aware of and will update the massage practitioner of any changes in my health status.

____ I understand that my records will be kept **confidential**.

_____ _____
client signature date

_____ _____
massage therapist signature date

Consent to Treatment of a Minor:

By my signature, I hereby authorize Natalie Grace Craig to administer massage, bodywork, or somatic therapy techniques to my child or dependent as she deems necessary.

_____ _____
signature of parent or guardian date