PERSONAL HEALTH INFORMATION

PERSONAL DATA

Name: _____ Date: _____ Referred by _____

Address: _____ Phone - Day: _____

City/State/Zip: _____ Phone - Eve: _____

Birthday: _____ Occupation/Employer: _____

Primary Health Care Provider: _____ Phone: _____

Permission to consult with primary provider? Please initial if yes. ☐ Yes _____ ☐ No

Emergency contact: _____ Phone: _____

MASSAGE HISTORY/TREATMENT INFORMATION

Have you ever received a professional massage? ☐ Yes ☐ No If yes, frequency _____ Date of last massage _____

What results do you want from your massage sessions? _____

Prioritize the areas of your body that you would prefer to be massaged _____

Please check the areas of your body that you give permission to receive massage:

☐ back ☐ legs ☐ buttocks ☐ arms ☐ abdomen ☐ chest ☐ neck ☐ head ☐ face ☐ other _____

Are you currently seeing a medical practitioner? Please explain if yes. ☐ Yes ☐ No _____

Are you currently seeing a psychotherapist or are you attending regular support group meetings? Please explain if yes ☐ Yes ☐ No _____

List stress reduction and exercise activities Include frequency _____

List current medications, including aspirin, ibuprofen, etc. _____

PREVIOUS HISTORY (Include year and treatment received)

Surgeries _____

Accidents _____

Inner Balancing Touch Center for Self Healing

HEALTH HISTORY

MUSCULO-SKELETAL

___ bone or joint disease _____
___ tendonitis _____
___ bursitis _____
___ broken/fractured bones _____
___ arthritis _____
___ sprains/strains _____
___ low back, hip, leg pain _____
___ neck, shoulder, arm pain _____
___ headaches/head injuries _____
___ spasms/cramps _____
___ jaw pain/TMJ _____
___ lupus _____
___ other _____

CIRCULATORY

___ heart condition _____
___ varicose veins _____
___ blood clots _____
___ high blood pressure _____
___ low blood pressure _____
___ lymphedema _____
___ breathing difficulty _____
___ sinus problems _____
___ allergies _____
___ other _____

INFECTIOUS DISEASE

___ disease name(s): _____
_____
_____

SKIN

___ allergies _____
___ rashes _____
___ athletes foot _____
___ warts _____
___ other _____

DIGESTIVE

___ constipation _____
___ gas/bloating _____
___ diverticulitis _____
___ irritable bowel syndrome _____
___ other _____

NERVOUS SYSTEM

___ herpes/shingles _____
___ numbness/tingling _____
___ chronic pain _____
___ fatigue _____
___ sleep disorders _____
___ other _____

REPRODUCTIVE

___ pregnant? Stage _____
___ PMS _____
___ other _____

OTHER

___ cancer/tumors _____
___ diabetes _____
___ eating disorders _____
___ depression _____
___ drug/alcohol addiction _____
___ nicotine/caffeine addiction _____

It is my choice to receive massage therapy. I realize that the treatment is being given for the well-being of my body and mind. This includes stress reduction, relief from muscular tension, spasm or pain, or for increasing circulation or energy flow. I agree to communicate with my practitioner any time I feel like my well being is being compromised.

I understand that massage practitioners do not diagnose illness, disease, or any physical or mental disorder; nor do they prescribe medical treatment, pharmaceuticals, or perform spinal thrust 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 that 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.

SIGNATURE: _____ DATE: _____