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? ☐ No ☐ Yes Date of last Massage _____

Do you have any allergies to massage lotion ingredients? ☐ No ☐ Yes

What results do you want from your massage session? _____

_____

_____

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

_____

_____

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

☐ back ☐ legs ☐ arms ☐ neck ☐ head ☐ face ☐ buttocks ☐ abdomen ☐ chest ☐ feet

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

_____

_____

Are you currently seeing a psychotherapist or are you attending regular support group meetings? Please explain if Yes.

☐ No ☐ Yes _____

_____

List stress reduction and exercise activities. Include frequency. _____

_____

_____

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

_____

_____

PREVIOUS HISTORY (Include year and treatment received)

Surgeries: _____

_____

_____

Accidents: _____

_____

_____

Revised 9/14/2016

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/TMJD _____
_____ lupus _____
_____ other _____

CIRCULATORY

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

AUTO IMMUNE/INFECTIOUS DISEASE

_____ Fibromyalgia _____
_____ Chronic Fatigue_____
_____ Rheumatoid Arthritis_____
_____ Lupus _____
_____ Epstein Barr _____
Other _____

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* _____
_____ *lymph node removal_____
_____ *port_____
_____ diabetes _____
_____ eating disorders _____
_____ depression _____
_____ drug/alcohol addiction _____
_____ nicotine/caffeine addiction _____
_____ swelling, redness or warmth in extremities _____
_____ history of blood clots_____
_____ medical device (such as pacemaker or defibrillator)_____

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. Treatment benefit may include stress reduction, muscular tension, spasm or pain relief, as well as increased circulation or energy flow. I agree to communicate with my student therapist any time I feel that my well-being is being compromised.

I understand that the practitioners are student therapists, under the supervision of an instructor and do not diagnose illness, disease or any physical or mental disorder, nor do they prescribe medical treatment, pharmaceuticals, or perform spinal manipulations. I acknowledge that massage is noea substitute for medical examination or diagnosis and that it is recommended that I see a primary helath care provider of that service.

I have stated all medical conditions that I am aware of and will update the student practitioner of may changes in my health status.

SIGNATURE: _____ DATE: _____

Int. _____ Date _____ Int. _____ Date _____
Int. _____ Date _____ Int. _____ Date _____
Int. _____ Date _____ Int. _____ Date _____
Int. _____ Date _____ Int. _____ Date _____

*Intitial and date intake form for **follow-** up and visits.*

Revised 9/14/2016