MYOFASCIAL RELEASE HISTORY FORM

The information requested below will assist us in providing you with safe treatments. Please ask your therapist if you have any questions about the information being requested. All information provided below will be kept as confidential unless allowed or required by law. Your written permission will be required to release any information.

Client Information

Name _____ Email _____

Phone (cell/day) _____ DOB _____ Age: _____

Address _____ City/State/Zip _____

Emergency Contact Name _____ Phone _____ Relationship _____

Occupation _____ Referred by: _____

Health Information

Anxiety / stress	☐ yes ☐ no	Muscle weakness	☐ yes ☐ no	**Notes**: _____	
Bleeding disorder	☐ yes ☐ no	Neuropathy	☐ yes ☐ no	_____	
Blood clot	☐ yes ☐ no	Osteoarthritis	☐ yes ☐ no	_____	
Bruise easily	☐ yes ☐ no	Osteoporosis	☐ yes ☐ no	_____	
Bursitis	☐ yes ☐ no	Phlebitis/varicose veins	☐ yes ☐ no	_____	
Cancer / tumor	☐ yes ☐ no	Rheumatoid arthritis	☐ yes ☐ no	_____	
Depression	☐ yes ☐ no	Sciatica	☐ yes ☐ no		
Diabetes	☐ yes ☐ no	Seizures	☐ yes ☐ no		
Fibromyalgia	☐ yes ☐ no	Stroke / CVA	☐ yes ☐ no		
Hearing loss	☐ yes ☐ no	Tuberculosis	☐ yes ☐ no		
High blood pressure	☐ yes ☐ no	Tendinitis	☐ yes ☐ no		
Low blood pressure	☐ yes ☐ no	TMJ disorder	☐ yes ☐ no		
Kidney disease	☐ yes ☐ no	Vertigo / dizziness	☐ yes ☐ no		
Multiple sclerosis	☐ yes ☐ no	Vision impairment	☐ yes ☐ no		

Any skin conditions? ☐ yes ☐ no _____

Neurological conditions? ☐ yes ☐ no _____

Heart condition? ☐ yes ☐ no _____

Autoimmune disorder? ☐ yes ☐ no _____

Digestive problem? ☐ yes ☐ no _____

Endocrine disorder? ☐ yes ☐ no _____

Respiratory disorder? ☐ yes ☐ no _____

Areas of swelling? ☐ yes ☐ no _____

Frequent headaches? ☐ yes ☐ no _____

Areas of numbness or decreased sensation? _____

Areas of broken skin? (e.g. rash, wounds) ☐ yes ☐ no If yes, where? _____

Any current infectious or contagious conditions? (e.g. HIV, TB, fungal infections, shingles, warts, etc.) ☐ yes ☐ no

If yes, please list: _____

Are you taking any medications? If yes, please list: _____

Any allergies or hypersensitivities? (oils, lotions, nuts, fruits, skin, etc.) ☐ yes ☐ no _____

Are you pregnant? ☐ yes ☐ no If yes, how many months: _____ Due date: _____

History of joint replacement surgery? ☐ yes ☐ no Which joint(s) ? _____

Any implants? (e.g. pacemaker, insulin pump, metal) ☐ yes ☐ no What, where? _____

Are you you currently under medical supervision or receiving other medical interventions?
If yes, please describe: _____

Recent injuries or medical procedures in the past 2 years? ☐ yes ☐ no Please describe: _____
_____

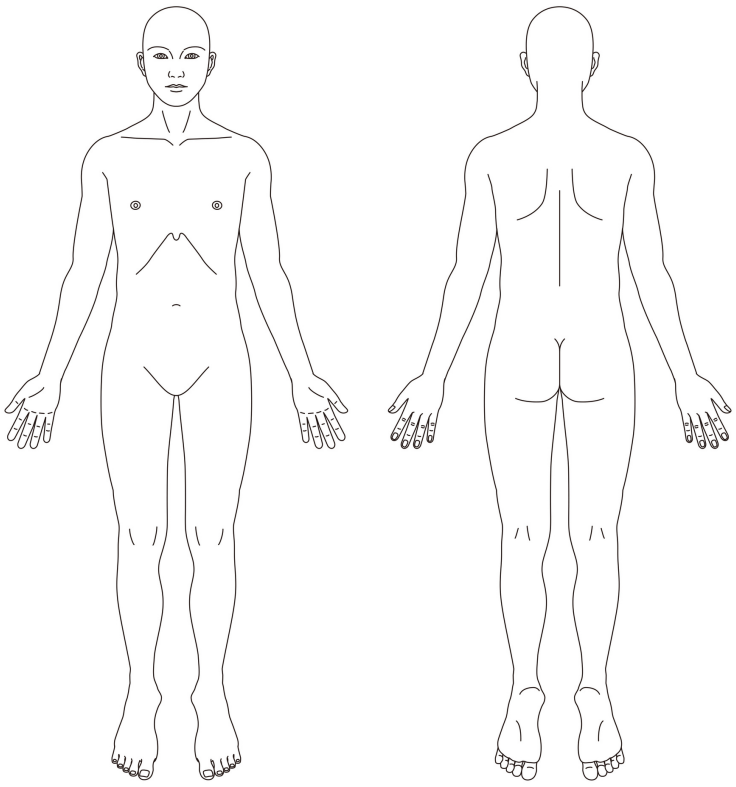
Please describe any other injuries or health conditions: _____
_____

Have you had professional massage before? ☐ yes ☐ no How recently? _____

Reason for seeking massage: ☐ Relaxation ☐ Specific problem _____

How much pressure do you prefer? ☐ Light ☐ Medium ☐ Firm

Please indicate any areas of pain or discomfort



By signing below, I acknowledge that I am aware of the benefits and risks of massage therapy and that I have completed this form accurately and truthfully to the best of my knowledge. I also agree to inform my massage therapist of any health or medical changes.

Client Signature _____ Date _____

Therapist Signature _____ Date _____