MASSAGE THERAPY HISTORY FORM

CLIENT INFORMATION

Date_____

Patient Name _____

Last Name First Name Middle Initial

Street Address _____

City _____ State _____ Zip _____

E-mail _____

Sex ☐ M ☐ F Age _____ Birthdate _____

☐ Married ☐ Widowed ☐ Single ☐ Minor ☐ Separated ☐ Divorced ☐ Partnered

Occupation _____

Patient Employer/School _____

Whom may we thank for referring you? _____

PHONE NUMBERS

Primary (_____)_____ Home (_____)_____

Cell (_____)_____ Work (_____)_____

Best time and place to reach you _____

IN CASE OF EMERGENCY, CONTACT:

Name _____ Relationship _____

Home (_____)_____ Work (_____)_____

CLIENT CONDITION

When did your symptoms appear? _____

What treatment have you already received for your condition?

☐ Medication ☐ Surgery ☐ Physical Therapy ☐ Chiropractic Care ☐ None ☐ Other

Type of pain: ☐ Sharp ☐ Shooting ☐ Throbbing ☐ Numbness ☐ Aching ☐ Dull

☐ Burning ☐ Tingling ☐ Cramps ☐ Stiffness ☐ Swelling ☐ Other

How often do you have this pain? _____ Is it constant or come and go? _____

Does it interfere with your ☐ Work ☐ Sleep ☐ Daily Routine ☐ Recreation

Activities or movements that are painful to perform ☐ Sitting ☐ Standing ☐ Walking ☐ Bending ☐ Lying Down

MASSAGE HISTORY

Have you ever received a professional massage? ☐ Yes ☐ No

Why did you come for our service? ☐ Relaxation ☐ Pain ☐ Therapy ☐ Other _____

What results would you like to achieve? _____

_____

Prioritize the areas of your body that you wish to be massaged. _____

Please note any areas of your body that you **prefer not to be** massaged. _____

HEALTH HISTORY

Please check conditions or symptoms you currently have or have had in the past:

☐ Anemia	☐ Cancer	☐ Hepatitis	☐ Multiple Sclerosis	☐ Sinus Problems
☐ Anorexia	☐ Chemical Dependency	☐ Hernia	☐ Osteoporosis	☐ Stroke
☐ Appendicitis	☐ Diabetes	☐ Herniated Disc	☐ Pacemaker	☐ Tendonitis
☐ Arthritis	☐ Emphysema	☐ Herpes	☐ Parkinson's Disease	☐ Thyroid Problems
☐ Asthma	☐ Epilepsy	☐ High Blood Pressure	☐ Pinched Nerve	☐ Tuberculosis
☐ Blood Clots	☐ Fibromyalgia	☐ HIV/AIDS	☐ Pneumonia	☐ Tumors, Growths
☐ Breathing Difficulty	☐ Fractures	☐ Jaw Pain/TMJ	☐ Polio	☐ Ulcers
☐ Bursitis	☐ Glaucoma	☐ Lymphedema	☐ Prosthesis	☐ Varicose Veins
☐ Bronchitis	☐ Head Injuries	☐ Migraine Headaches	☐ Rheumatoid Arthritis	☐ Whiplash
☐ Bulimia	☐ Heart Disease	☐ Mononucleosis	☐ Rheumatic Fever	☐ Other _____

MEDICATIONS

Medication: Taking For:

_____ _____

_____ _____

ALLERGIES

_____

_____

_____

VITAMINS/HERBS/MINERALS

_____

_____

_____

EXERCISE

☐ None
☐ Moderate
☐ Daily
☐ Heavy

WORK ACTIVITY

☐ Sitting
☐ Light Labor
☐ Standing
☐ Heavy Labor

LIFESTYLE

☐ Smoking Packs/Day _____
☐ Coffee/Caffeine Cups/Day _____
☐ Alcohol Drinks/Week _____
☐ High Stress Level Reason _____

Are you pregnant? ☐ Yes ☐ No Due Date _____

Please list any medical conditions, surgeries, accidents, and bone, joint, nerve or muscle diseases or injuries not specified above.

_____ _____ _____ _____

Date Date

AUTHORIZATION

To the best of my knowledge, the above information is complete and correct. I understand that reporting incomplete or inaccurate information can be dangerous to my health. I understand that I am solely responsible for any errors or omissions that I may have made in the completion of this form. I understand that it is my responsibility to inform my health care provider if I ever have a change in health.

I understand that massage therapy services are for the primary purpose of short-term relaxation and the relief of muscular tension. I understand that massage therapy services are in no way a substitute for examination, diagnosis or treatment by a physician. I understand that individuals providing massage therapy services are not qualified to diagnose, prescribe or treat any physical or mental illness and are not qualified to perform spinal or skeletal adjustments. I acknowledge that any information I receive from individuals performing massage therapy services is educational in nature and is to be used at my own discretion.

_____ _____

Signature of Patient, Parent, Guardian or Personal Representative Date

_____ _____

Please print name of Patient, Parent, Guardian or Personal Representative Relationship to Patient