Massage Therapy Health Information Form

Patient Information:

Name: _____ DOB _____

Address: _____

Contact #: Home: _____ Cell: _____ Work: _____

Email: Personal: _____ Work: _____

Emergency Contact: _____

Primary Health Care Physician: _____

Health Information:

Reason for massage today: _____

Primary Health Concern: _____

Daily activities that aggravate condition: _____

Daily activities limited by condition: _____

How do you reduce stress/pain? _____

Health History: Use a second page if necessary to provide detailed information.

Surgeries, Injuries, & Illnesses within the past 2 years: _____

_____

Please check all current & previous health conditions: Date of Injury: _____

__rheumatoid arthritis
__osteoarthritis
__osteoporosis
__scoliosis
__lupus
__broken bones
__headaches
__spinal issues
__TMJ
__spasms/cramps
__sprains/strains
__tendonitis
__bursitis
__sciatica
__neck/shoulder/arm pain
__low back
__leg pain
__numbness/tingling
__chronic pain

__fatigue
__sleep disturbances
__fever
__sinus
__rashes
__allergies
__depression
__concussions/head injuries
__dizziness
__asthma
__memory or confusion issues

__heart disease
__stroke
__blood clots
__lympedema
__high or low blood pressure
__irregular heart beat
__poor circulation
__swollen ankles
__varicose veins
__chest pain

__abdominal pain
__bladder/kidney/prostate
__bowel issues
__thyroid
__diabetes
__pregnancy
__painful menses
__fibrotic cysts
__benign or malignant tumors

__alcohol __tobacco

OTC medications _____

_____

RX medications _____

_____

Signature _____ Date _____