Today's date_____

Health History Form

This questionnaire has been designed to assist your massage therapist in providing optimal therapeutic care and service. All information provided will be kept in the strictest confidence.

Name _____ Date of Birth _____

Address _____Email _____

City _____State ____ Zip_____

Home phone _____Work phone _____Cell_____

Occupation _____

Emergency contact _____ Relationship _____

Home phone _____Work phone _____Cell_____

Name of primary health care practitioner _____

Medical conditions for which you are currently being treated _____

_____

Referred by _____

When was your last therapeutic massage? _____

What benefits do you hope to gain through massage? _____

Medical Information

Today's primary concern _____

Level of discomfort: mild _____ moderate _____severe_____

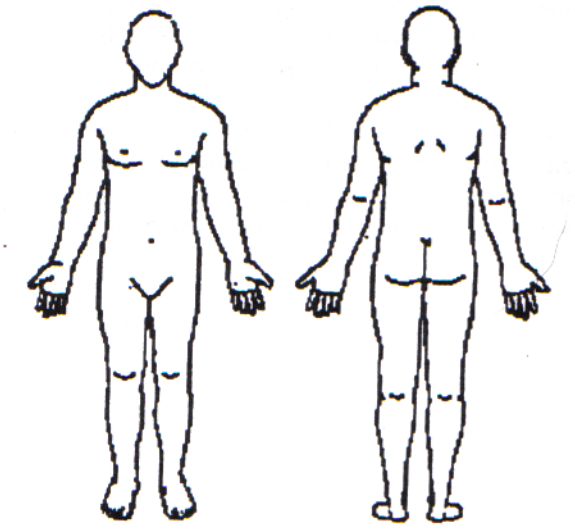
Duration: constant _____ intermittent _____other _____

When did you first notice the discomfort? _____

What activities cause discomfort? _____

What helps relieve it? _____

Other areas of concern: _____



Circle or mark an "X" on all areas of the body that you feel pain, tenderness, numbness, tingling, or other discomfort.

Pre-massage Pain Scale
0 ----------10

Post-massage Pain Scale
0 ----------10

Medical History
Please check all the following that apply to you:

Heart Problems	Blood Pressure Problems	Skin Problems	Spinal/Back Problems
Digestive/Intestinal Problems	Varicose Veins	Breathing Problems	Immune Deficiency Diseases
Sleep Problems	Frequent headaches	Cancer-Related Issues	Jaw Pain/Sinus/Dental Problems
Hip or Leg Problems	Mental/Emotional Stress	Seizures/Epilepsy	Diabetic
Grief/Depression	Allergies:	Surgeries:	Accidents:
Wear: Contacts		Dentures	Hearing Aid
Have: Implants		Prosthesis	Pacemaker
Other Conditions:			
Pregnant: _____ # of weeks		Tendency to be: Hot Cold	
Average daily intake of : Tobacco		Caffeine	Alcohol

Any areas of body sensitive to touch or therapist should avoid?

_____

Your choice of exercise or stress-reducing activities:

_____

Current medications, supplements or complementary therapies (i.e. chiropractic care):

_____

Informed Consent

I understand that massage therapy is not a substitute for medical care and that any information provided by the therapist is for educational purposes only and is not diagnostic or prescriptive in nature.

Because a massage therapist must be aware of existing physical and mental conditions, I have stated all my known medical conditions and taken it upon myself to keep the massage therapist updated on my physical and mental health.

It is also understood that any illicit or sexually suggestive remarks or advances made by me will result in immediate termination of the session and I will be liable for payment of the scheduled appointment. I understand that I will be charged for appointments not cancelled 24 hours in advance and all returned checks incur a fee of $25.00.

Signature: _____Date: _____