

Massage Therapy Health Information Form

Patient Information:

Name: _____ DOB _____

Address: _____ City: _____ State: _____ Zip: _____

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: _____

- | | | | |
|---|---|---|---|
| <input type="checkbox"/> rheumatoid arthritis | <input type="checkbox"/> fatigue | <input type="checkbox"/> heart disease | <input type="checkbox"/> abdominal pain |
| <input type="checkbox"/> osteoarthritis | <input type="checkbox"/> sleep disturbances | <input type="checkbox"/> stroke | <input type="checkbox"/> bladder/kidney/prostate |
| <input type="checkbox"/> osteoporosis | <input type="checkbox"/> fever | <input type="checkbox"/> blood clots | <input type="checkbox"/> bowel issues |
| <input type="checkbox"/> scoliosis | <input type="checkbox"/> sinus | <input type="checkbox"/> lymphedema | <input type="checkbox"/> thyroid |
| <input type="checkbox"/> lupus | <input type="checkbox"/> rashes | <input type="checkbox"/> high or low blood pressure | <input type="checkbox"/> diabetes |
| <input type="checkbox"/> broken bones | <input type="checkbox"/> allergies | <input type="checkbox"/> irregular heart beat | <input type="checkbox"/> pregnancy |
| <input type="checkbox"/> headaches | <input type="checkbox"/> depression | <input type="checkbox"/> poor circulation | <input type="checkbox"/> painful menses |
| <input type="checkbox"/> spinal issues | <input type="checkbox"/> concussions/head injuries | <input type="checkbox"/> swollen ankles | <input type="checkbox"/> fibrotic cysts |
| <input type="checkbox"/> TMJ | <input type="checkbox"/> dizziness | <input type="checkbox"/> varicose veins | <input type="checkbox"/> benign or malignant tumors |
| <input type="checkbox"/> spasms/cramps | <input type="checkbox"/> asthma | <input type="checkbox"/> chest pain | |
| <input type="checkbox"/> sprains/strains | <input type="checkbox"/> memory or confusion issues | <input type="checkbox"/> alcohol | <input type="checkbox"/> tobacco |
| <input type="checkbox"/> tendonitis | | | |
| <input type="checkbox"/> bursitis | | OTC medications _____ | |
| <input type="checkbox"/> sciatica | | _____ | |
| <input type="checkbox"/> neck/shoulder/arm pain | | | |
| <input type="checkbox"/> low back | | | |
| <input type="checkbox"/> leg pain | | RX medications _____ | |
| <input type="checkbox"/> numbness/tingling | | _____ | |
| <input type="checkbox"/> chronic pain | | | |

Signature _____

Date _____