

Medical History

Name _____ Date _____
Address _____ City _____
State & Zip _____ Phone (H) _____ (W) _____
Date of Birth _____ Occupation _____ Physician _____
Medications _____
Referred By _____

Have you had massage before?

Name anything that stands out from past massages that was good or not so good?

What is your reasoning for choosing massage today?

What are your exercise and stretching habits?

Do receive any other forms of alternative care (acupuncture, chiropractic care...)?

Please provide your email if you would like to receive communication via email.

Circle any conditions that you may have or have been diagnosis with

Allergies	Depression	Pins/Pacemaker
Arthritis	Diabetes	Pregnancy
Anemia	Digestion Problems	Psychiatric
Anxiety	Dizziness/Fainting	Respiratory
Asthma	Endocrine Issues	Seizure/Epilepsy
Athlete's Foot	Fatigue	Sinus Problems
Bleeding	Headaches	Skin Conditions
Bruising (or bruise easily)	Hepatitis	Smoker
Blood Pressure Problems	Hernia	Stress
Bursitis	Joint Problems	Surgery
Cancer	Kidney/Urinary	TMJ
Cardiac Issues	Liver/Gall Bladder Neuritis	Ulcers
Circulation Problems	Muscle Strains/Sprains	Varicose Vein
Contact Lenses	Osteoporosis	Vertebral/Disc Problems
Cuts	Phlebitis/Blood Clots	

Please describe any other conditions that you have that is not listed above:

As a massage therapist it is my responsibility to treat muscles, increase relaxation and promote a mind/body connection. As a therapist I do not diagnosis or provide any other services. The appointment you schedule is reserved for you, if you can not keep your

appointment it is required that you give **24 hours notice**. If there is less than 24 hours cancellation you **will be charged for you missed appointment**.

Signature _____ Date _____