



PERSONAL HEALTH INFORMATION

Name: _____ Referred by: _____
 Address: _____ Phone: _____
 City/State/Zip: _____ Email: _____
 Birthday: _____ Preferred contact method: _____

Emergency Contact: _____ Relation: _____ Phone: _____

BODY WORK HISTORY

Have you received Swedish massage before? What frequency? _____

Have you received Hot Stone massage before? _____

What is your major reason for seeking massage therapy? _____

When did you first notice this condition? _____

What aggravates it and what relieves it? _____

Has there been a medical diagnosis? _____

Are you experiencing loss of range of motion in this area or any others? _____

Please circle all areas of the body which you give permission to receive massage:

Back Legs Feet Buttocks Arms Hands Abdomen Upper Pectorals Neck Head Face

What areas do you want to focus on? _____

Are you comfortable laying on your back and your stomach for long periods? _____

PERSONAL HABITS

What is your occupation and what position are you most commonly in everyday? (ex. sitting at desk) _____

What do you do when you are stressed? _____

What do you do for exercise? _____

What position do you sleep in? _____

MEDICAL HISTORY

Primary Health Care Provider: _____ Phone: _____

Other Practitioners regularly visited: _____ Phone: _____

Permission to consult with these individuals? _____

Are you currently being treated by a medical professional or psychotherapist? If yes, please explain. _____

Please list all medications and reason for taking them: _____

Please list (date and description) of any accidents or operations: _____

Please check any conditions which apply to you:

Musculo-skeletal

- Bone or joint disease
- Tendonitis or bursitis
- Fractured/broken bones
- Sprains/strains
- Spasm/cramps
- Arthritis
- Headaches
- Scoliosis
- Inflammation
- Jaw pain
- Other

Circulatory/Respiratory

- High or low blood pressure
- Heart condition
- Varicose veins
- History of blood clots
- Dizziness/fainting
- Asthma
- Allergies
- Sinus problems
- Difficulty breathing
- Lymphedema
- Other

Skin

- Rashes
- Allergies
- Athlete's Foot
- Warts
- Other

Nervous System

- Multiple Sclerosis
- Fibromyalgia
- Areas of numbness/tingling
- Herpes/ shingles
- Parkinson's Disease
- Other

Digestive

- Irritable bowel syndrome
- Constipation or Diarrhea
- Diverticulitis
- Other

Other

- Any infectious disease
- Cancer
- Diabetes
- Depression
- Currently Pregnant
- Alcohol/Nicotine/ Drug Addiction

Please explain any of the conditions checked above: _____

It is my choice to receive massage therapy and I understand that it is given for the well-being of my body and mind. This includes stress reduction, relief from muscular tension, spasm or pain, and increasing circulation and energy. I agree that I will communicate with my practitioner if I feel my well being is being compromised.

In the case of hot stone massage, I understand that basalt stones warmed to 120 degrees Fahrenheit will be in direct contact with my skin during this treatment. Therefore, to avoid potential burns, I will communicate with my practitioner throughout the massage about my temperature comfort level.

I understand that massage practitioners do not diagnose illness/disease or prescribe medical treatment, pharmaceuticals or perform spinal thrust manipulations.

I understand that cancellations without 24 hour notice will be charged for the session. I also understand that late arrivals will be charged for the full amount for the service booked and will receive as much of the service as time allows.

I have provided accurate information on this form and will update my practitioner of any changes.

SIGNATURE: _____ DATE: _____