Personal Information and Medical History

This history is confidential. The information will help determine if therapeutic massage is indicated and which procedures are appropriate.

Personal Information

Name ______________________________ Today's Date ____________ Your Birth date __________

Street ______________________________ ____Male ____Female

City ________________ ST___ ZIP ________ Emergency Contact ____________________

Phone: CELL ______________________________ His/her Phone number ______________

EMAIL ______________________________

Please check problems you've observed. Circle items that are frequent or severe

Head and Neck
____Headaches
____Neck pain/tightness
____Lumps or swelling
Other ____________________

Eyes
____Blurred vision
____Wear contacts
____Wear glasses
____Excessive or too little tearing
Other ____________________

Musculoskeletal
____Aching muscles
____Muscles sore to the touch
____Aching joints
____Chronic low back problems
____Chronically tired
____Difficulty in doing physical tasks (list) ____________________
Other ____________________
____

Heart/Circulation
____High blood pressure
____Low blood pressure
____Swelling in feet or ankles
____Leg cramps
____Varicose/spider veins
Other ____________________

Female Genito/Urinary
Pregnant? Due ____/____/____
____Lump or pain in breasts
____Menstrual cramps
____Urinary tract infection
____Pain in genitals/groin
Other ____________________

Male Genito/Urinary
____Painful/slow urination
____Nighttime urinary frequency
____Urinary tract infection
____Pain in genitals/groin
Other ____________________

Digestive System
____Bloating
____Constipation
____Diarrhea
Other ____________________

Skin
____Bruise easily
____Any open cuts or sores
____Skin Allergies
____Tender areas on skin
____Infection or inflammation
Other ____________________

Nervous System
____Difficulty in relaxing
____Difficulty in sleeping
Other ____________________

Respiratory System
____Easily out of breath
____Airborne allergies
Other ____________________

Check problems diagnosed by a doctor. Circle if you're currently being treated

____Arthritis/rheumatism
____Asthma
____Broken Bones (list)
____Bursitis
____Carpal Tunnel Syndrome
____Chronic Fatigue Syndrome
____Diabetes
____Disk problem (slipped, herniated, bulging)
____Emphysema
____Epilepsy
____Fibrositis/fibromyalgia

____Heart disease what type? ____________________
____Hypertension
____Infection or Inflammation
____Kidney/bladder/prostate (list) ____________________
____Lupus Erythematosus
____Migraine headaches
____Muscular Dystrophy
____Multiple Sclerosis
____Osteoporosis
____Parkinson's' Disease

____Sciatica
____Sprains/dislocations (list) ____________________
____Stroke/CVA/TIA
____Thrombosis/Phlebitis
____TMJ Dysfunction
____Tumors/cancer (list)
____Tuberculosis
____Ulcer/colitis/diverticulitis
____Implants (plastic surgery, metal, or electric devices list) ____________________

Please complete the other side

Please check the following activities/positions that you frequently use.

____ Standing	____ Stooping	____ Kneeling	____ Driving
____ Sitting	____ Bending	____ Lifting	____ Walking/running

What is your occupation?

Please list sports or exercise programs you participate in. ____________________

Please list any physical activities that cause you a problem ____________________

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What is your current problem that you believe massage therapy will benefit ____________________

Please list all accidents and physical injuries you've had. Please carefully consider childhood accidents, automobile accidents, sports injuries, *etc*. Don't limit your list to events that caused broken bones or hospitalization. If it hurt for several days when it happened, it could be significant to your current problem.

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How did you select this office for your massage therapy? ____________________

While therapeutic massage is recognized as relatively non-invasive, you may have, or develop, conditions that would affect the decision on whether or not you should receive massage. Please be certain that the information on this form is complete and accurate, and keep us updated of any changes in your medical circumstances.

To the best of my knowledge, the above information is accurate and complete. I'll let you know if it changes.

Signature ____________________ Date ____________________

Name: ______________________________ Date: ____________

Please identify current problem areas in your body by drawing the appropriate symbols on the diagrams below.

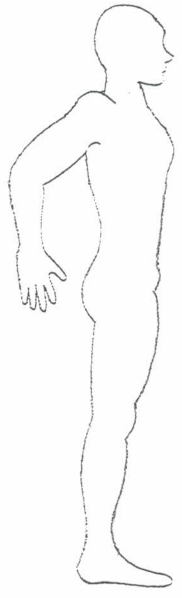
Key

○ Circle areas where pain exists

⊙ Circle areas with small dots where **extreme pain** exists

✕ Put an "X" over stiff areas

≋ Draw squiggly lines over areas of **numbness** or **tingling**



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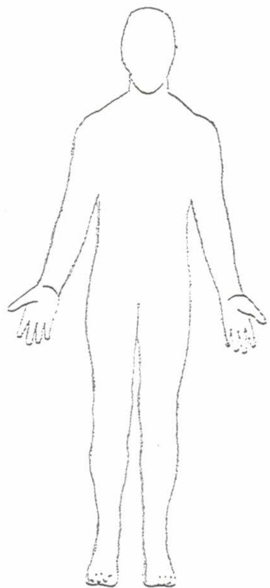
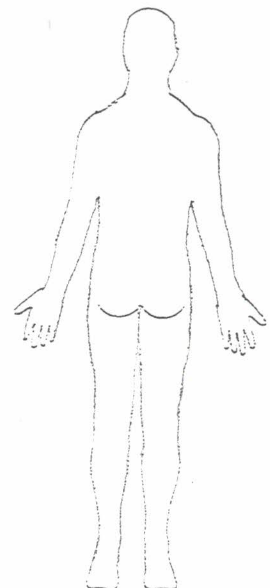


Front



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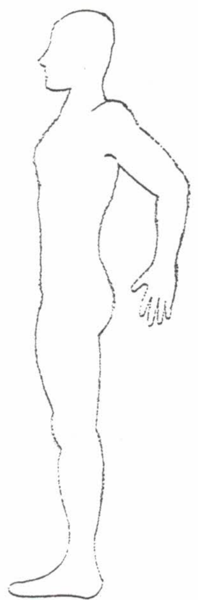

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Comments: ______________________________

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