Professional Massage Therapy Werks

Confidential Health History Form

Name: _____ **Address:** _____ **City / State / Zip:** _____

Home Phone: _____ **Work Phone:** _____ **Cell Phone:** _____

E-Mail Address: _____ **Emergency Contact:** _____ **Contact Number:** _____

Date of Birth: _____ **Occupation:** _____ **Therapist:** _____ **Referred By:** _____

Family Doctor: _____ **Current Medications:** _____

Please list current hobbies, recreational activities: _____

Have you ever had a professional massage before: YES NO **Would you like to receive our e-mail specials?** YES NO

Present Symptoms: What is your major complaint, condition or discomfort area(s) needing attention? _____

_____

Any Recent Injuries or Surgeries? _____

Please check the following conditions that apply to you, past and present. Please add your comments to clarify the condition.

Musculo-Sketetal

- ☐ Headaches
- ☐ Joint stiffness/swelling
- ☐ Spasms/cramps
- ☐ Broken/fractured bones
- ☐ Strains/sprains
- ☐ Back, hip pain
- ☐ Shoulder, neck, arm, hand pain
- ☐ Leg, foot pain
- ☐ Chest, ribs, abdominal pain
- ☐ Jaw pain / TMJ
- ☐ Tendonitis / Bursitis
- ☐ Arthritis
- ☐ Osteoporosis
- ☐ Scoliosis
- ☐ Other: _____

Circulatory & Respiratory

- ☐ Dizziness
- ☐ Shortness of breath
- ☐ Fainting
- ☐ Varicose veins
- ☐ Blood clots
- ☐ Stroke
- ☐ Heart condition
- ☐ Allergies
- ☐ Sinus problems
- ☐ Asthma
- ☐ High blood pressure
- ☐ Low blood pressure
- ☐ Lymphedema
- ☐ Other _____

Skin

- ☐ Rashes
- ☐ Allergies
- ☐ Athlete's Foot
- ☐ Other: _____

Digestive

- ☐ Nervous stomach
- ☐ Indigestion
- ☐ Constipation
- ☐ Diarrhea
- ☐ Diverticulitis
- ☐ Irritable bowel syndrome
- ☐ Other: _____

Nervous System

- ☐ Numbness / tingling
- ☐ Fatigue
- ☐ Chronic pain
- ☐ Sleep Disorders
- ☐ Ulcers
- ☐ Paralysis
- ☐ Herpes / Shingles
- ☐ Cerebral Palsy
- ☐ Epilepsy
- ☐ Chronic Fatigue Syndrome
- ☐ Multiple Sclerosis
- ☐ Muscular Dystrophy
- ☐ Parkinson's Disease
- ☐ Spinal Chord Injury
- ☐ Other: _____

Reproductive System

- ☐ Currently Pregnant
- ☐ Other: _____

Other

- ☐ Cancer: Type _____
- ☐ Diabetes
- ☐ Depression
- ☐ Fibromyalgia
- ☐ Eating Disorder
- ☐ Hearing Impaired
- ☐ Visually Impaired
- ☐ Nervous Tension
- ☐ Infectious Disease
- ☐ Other: _____

I have stated all conditions that I am aware of and this information is true and accurate. I will inform my health care provider of any changes in my physical condition and keep my massage therapist updated on my health history. I understand that massage therapy is for the purpose of stress reduction, relief from muscular tension, improved circulation and energy flow. I understand that the massage therapist does not diagnose illness or disease nor perform spinal manipulation. As such, the massage therapist does not prescribe medical treatment or pharmaceuticals. Client Signature: _____ Date: _____