MASSAGE & BODYWORK
In Touch Well-Being

Confidential Medical History

❑ CL
❑ CC
❑ TY
❑ SL

Therapist_____

Date:_____

Please Print Clearly

Name :_____ Home Phone: ( )_____

Address:_____ Work Phone: ( )_____

City :_____Zip:_____ Cell Phone : ( )_____

E-Mail:

Birth Date:_____ Gender: M / ☐ ☐ Occupation:_____

How did you here about us?_____

Are you presently being treated by: MD?_____ PT?_____ Other?_____

Are you taking medication for anything? _____

Any surgery in the last year? _____

Please check the appropriate box for any of the following which you now have or have had previously.
We want all the facts about your health before treating you.

GENERAL

- ☐ Allergies - Food
- ☐ Allergies - Seasonal
- ☐ Asthma
- ☐ Cancer
- ☐ Chest Pain
- ☐ Contagious Condition
- ☐ Diabetis
- ☐ Epilepsy
- ☐ Headache
- ☐ Kidney Failure
- ☐ IBS
- ☐ Nerve Pain
- ☐ Numbness

where?_____

MUSCULAR/SKELETAL

- ☐ Arthritis
- ☐ Bursitis
- ☐ Foot Trouble
- ☐ Hip Replacement
- ☐ Knee Replacement
- ☐ Lower Back Pain
- ☐ Multiple Sclerosis
- ☐ Neck Pain or Stiffness
- ☐ Osteoporosis
- ☐ Pain Between Shoulders
- ☐ Sciatica

SKIN

- ☐ Acne
- ☐ Bruise Easily
- ☐ Eczema / Psoriasis

CARDIO-VASCULAR

- ☐ Heart Disease
- ☐ High Blood Pressure
- ☐ Poor Circulation
- ☐ Phlebitis
- ☐ Stroke
- ☐ Varicose Veins

FOR WOMAN ONLY

- ☐ Are you pregnant

How far along?_____

- ☐ Miscarriage

Is this your first massage? Yes☐ No☐ Date of last massage _____

What are your massage goals?

☐ Relaxation ☐ Pain Management ☐ Stress Relief ☐ Energy Cleansing
☐ Pampering ☐ Body Maintenance ☐ Sports Enhancemnet ☐ Injury Relief
Other _____

Is there anything else the therapist should be aware of? _____

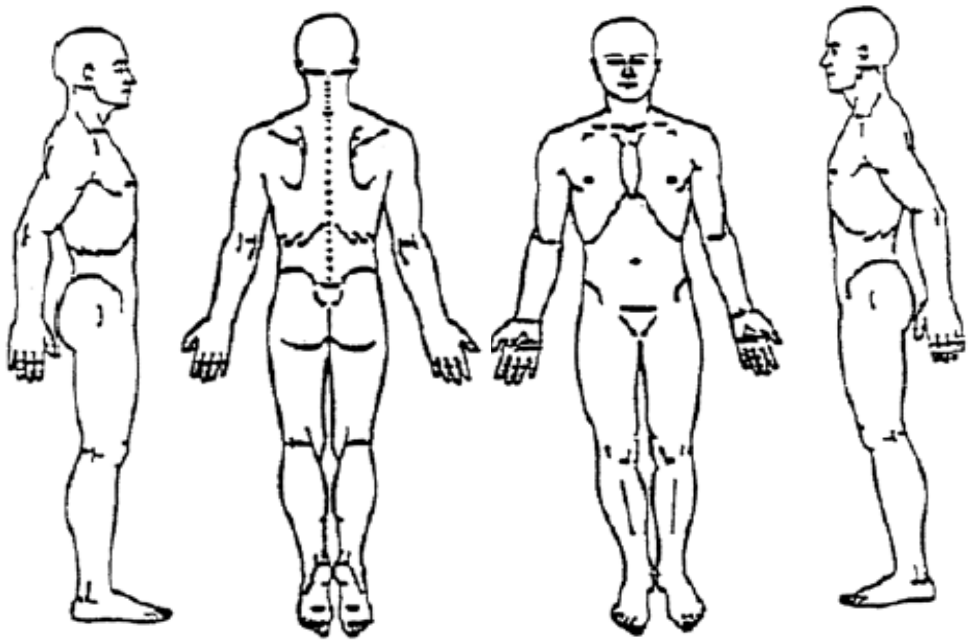
_____

HAVE YOU EVER	DESCRIBE BRIEFLY (Include Dates)
☐ Been knocked unconscious?	_____
☐ Used a cane, crutch, or other support?	_____
☐ Been treated for a spine/nerve disorder?	_____
☐ Been hospitalized (other than surgery)?	_____
☐ Other _____	

LIFESTYLE

HOME LIFE	☐ Stressful	☐ Stressful sometimes	☐ Not stressful
WORK LIFE	☐ Stressful	☐ Stressful sometimes	☐ Not stressful
EXERCISE	☐ Regularly	☐ Sometimes	☐ Not usually
EAT WELL	☐ Always	☐ Usually	☐ Not usually
SLEEP WELL	☐ Always	☐ Usually	☐ Not usually

THERAPIST COMMENTS:



Indicate Areas of Pain

I understand that the massage therapy that I am given is for the purpose of stress reductions, relief from muscular tension or spasm, and/or for improving circulations. I understand that a massage therapist neither diagnoses illness, dissease, or any other medical, physical, or qualified physician for any physical ailment that I have.

I agree to pay for all services at the time they are rendered.

Signature:
_____Date:_____

NOTE: Signature is mandatory to receive treatment.