CONFIDENTIAL HEALTH HISTORY

Name: _____

Phone: _____ Cell: _____

Address: _____ City: _____ State:___Zip:_____

E-mail: _____Date of birth: _____ M___ F ___

Occupation: _____ Work #:_____

Emergency contact/phone: _____

Referred by: _____ Ad: _____Website: _____

Have you had massage before?_____

Major areas of pain of concern: _____

When did you first notice it?_____What brought it on? _____

Is the condition getting worse? _____ Was there a medical diagnosis?_____

Doctor's name: _____ Phone: _____

Permission to talk to your Doctor? _____

List of medications, including over the counter, herbals: _____

_____

List all surgeries: _____

_____

List all injuries: _____

_____

As these may cause old scar tissue which may be affecting you now.

Infectious diseases include HIV, HEPATITIS, TB. Please specify and inform of any changes in the future:

_____

_____

Do you have stress reduction activities (exercise/meditation/other): _____

_____ Frequency?_____

Please check/circle any that pertain to your present or past history, give approximate year if possible

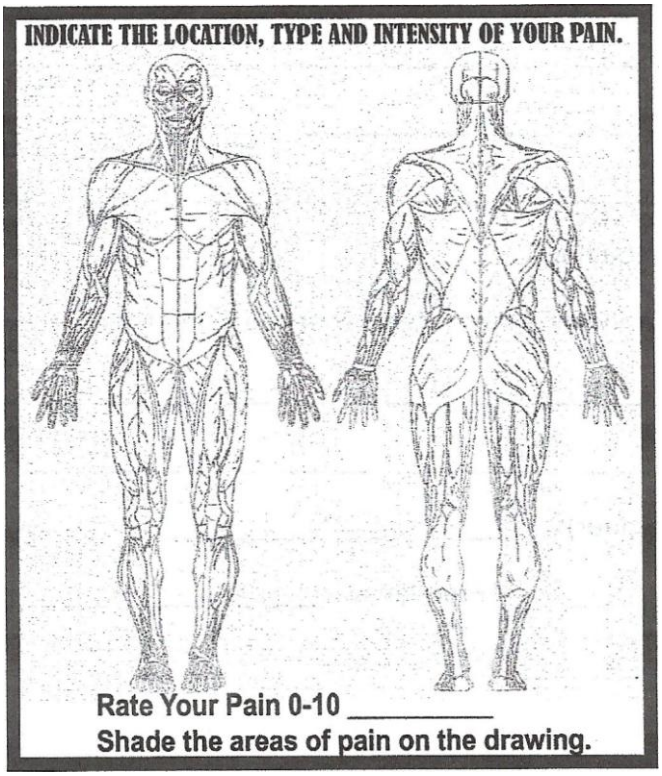
___ Abdominal/digestive condition _____
___ Allergies _____
___ Athletes foot/other fungus _____
___ Balance issues _____
___ Bleeding/aneurism _____
___ Blood clots/blood thinning meds _____
___ Blood pressure: hi/low/controlled? _____
___ Bone fractures _____
___ Cancer _____
___ Chemo/radiation/date _____
___ Cellulitis _____
___ Diabetes/type _____
___ Dizziness/fainting _____
___ Edema/Lymphedema/Swollen ankles _____
___ Emotional: tendency to: Worry/Fear/Anger/ Grief/Anxiety/Stress _____
___ Fibromyalgia/chronic fatigue _____
___ Headaches/head injury _____
___ Heart condition/CHF/implants _____
___ Herpes/shingles _____
___ Joint injury/replacement surgery _____
___ Kidney disease _____
___ Loss of memory _____
___ Open wounds/sores _____
___ Osteoporosis _____
___ Pregnant/stage? _____

___ Respiratory concerns _____
___ Asthma/COPD _____
___ Oxygen use _____
___ Hay fever _____
___ Sinus condition _____
___ Smell sensitivities _____
___ Seizures/epilepsy _____
___ Skin disease/rash _____
___ Sleeping problems _____
___ Stroke/TIA _____
___ Thyroid/hormone condition _____
___ Varicose veins/phlebitis _____
___ Vascular insufficiency _____

Pain/Discomfort

___ Arthritis/type? _____
___ Carpal Tunnel Syndrome _____
___ Jaw pain/TMJD _____
___ Shoulder/elbow/wrist/hand _____
___ Hip/knee/ankle/foot _____
___ Neck/upper back _____
___ Low back/sciatica _____
___ Disc problems _____
___ Muscle spasms/cramps _____
___ Neuropathy/numbness/tingling _____
___ Unidentified pain _____

___ OTHER _____



I have stated all medical conditions of which I am aware, and will update the massage practitioner of any changes in my health status. I understand that certain medical conditions are contraindications for massage therapy, and that I am responsible for fully disclosing all pertinent medical history. I agree to communicate with my practitioner any time I feel that my well being is compromised.

I understand that payment is due at the time of treatment. I agree to give 24 hours notice of cancellation of an appointment. If less than 24 hours notice is given or I fail to show up for my appointment at all, I agree that the therapist may charge for the time if unable to fill the appointment time with another client. Cases of extreme emergency are considered exceptions.

Date _____

Signature _____