Health History Form

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Name: _____ Date of Birth _____ /_____ /_____

Address: _____ Height: _____ Weight: _____

Telephone: _____ Gender: _____ Male _____ Female

Referred by: _____ Occupation: _____

Have you ever had a massage before? _____ Emergency Contact: _____

If so, what type? _____ Phone: _____

Do you have or have you had any of the following conditions? Check appropriate lines:

_____ High Blood Pressure	_____ Stiff Neck	_____ Recent Surgery
_____ Low Blood Pressure	_____ Whiplash	_____ Fractures
_____ Heart Condition	_____ Serious Accident	_____ Recent Fever
_____ Nervous Condition	_____ Varicose Veins	_____ Arthritis
_____ Eating Disorders	_____ Any Contagious Disease	_____ Inflammation
_____ Diabetes	_____ Internal Organ Dysfunction	_____ Insomnia
_____ Epilepsy	_____ HIV Virus	_____ Headaches
_____ Cancer	_____ Skin Disorders	_____ Pregnancy
_____ Decreased Range Of Motion	_____ Allergies	_____ Other

Are you currently under the care of a physician? _____

Are you currently taking any medications? _____ If so, list medications you are taking and what they are prescribed for:

_____

_____

Are you currently under the guidance of a coach or certified athletic trainer? _____

Please list any exercise programs/sports you are currently active in: _____

_____

_____

I have completed the information above to the best of my knowledge. I understand that the massage I am receiving is designed as a health aid and does not take the place of a doctor's care. Information exchanged during my massage session is educational in nature and is intended to help me become more aware of my own health. If I feel uncomfortable at any time during my massage, I will ask for the massage to end.

As a courtesy to the therapist and other clients, I agree to adhere to the 24 hour cancellation policy.

Signature: _____ Date: _____