Client Health History
Confidential Information
(Please print clearly)

Date_____
Name _____ Home #_____Work #_____
Address_____City_____State_____
Date of Birth _____Age_____ Gender_____
Occupation_____ Referred by_____

Have you ever received massage therapy? If yes date of last session_____
☐ Yes ☐ No

What type of massage have you received? Check all that apply.
☐ Deep Tissue ☐ Sports related
☐ Swedish ☐ Other

Are you currently taking medication? If yes please list the Medications?
_____
_____
Are you currently under the care of a Physician?
Physician's name_____
If yes please describe_____
_____
Women Only
Are you currently pregnant? If yes please list due date_____
☐ Yes ☐ No

Do you have a history of any of the following medical conditions? (Check all that apply)

☐ Accident	☐ Whiplash	☐ Surgery
☐ Seizures	☐ Headache	☐ Neck pain
☐ Congestive hear failure	☐ Recent heart attack	☐ Other heart condition
☐ High blood pressure	☐ Stroke	☐ Cancer
☐ Respiratory problems	☐ Diabetes	☐ Blood clots/phlebitis
☐ Arthritis, bursitis or gout	☐ Cellulites	☐ Colitis
☐ Osteoarthritis	☐ Fibromyalgia	☐ Varicose veins
☐ Edema (swelling)	☐ Nervous tension	☐ Abdominal pain
☐ Low back pain	☐ Disk problems	☐ Mid back pain
☐ Decreased Range of motion	☐ Sprains	☐ Broken bones
☐ Joint aches	☐ Breast augmentation	☐ Wear any prosthesis
☐ Wear contacts	☐ Allergies to oil or perfumes	

Please list any other medical conditions that may not be listed.
_____
_____

Do you have any of the following today?
(check all that apply).

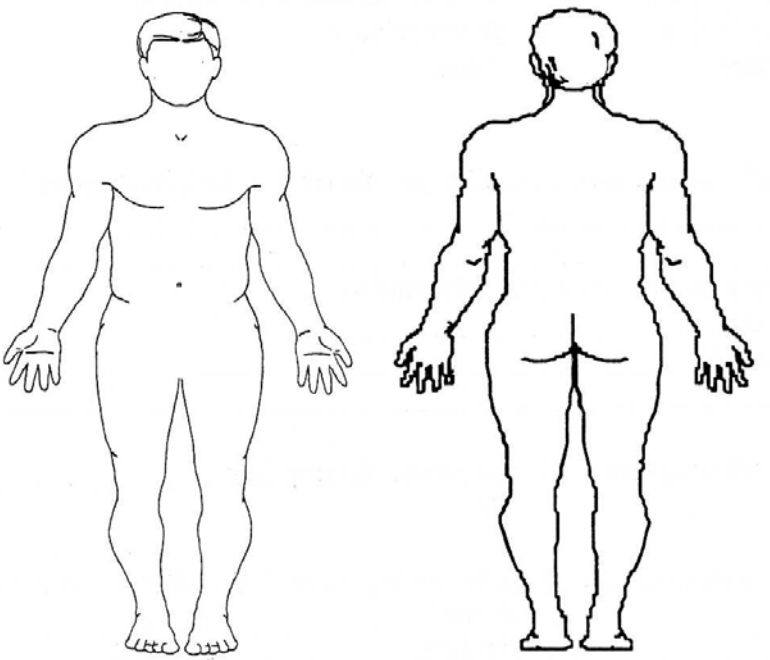
☐ Sunburn	☐ Inflammation	☐ Severe pain
☐ Headache	☐ Fever	☐ Cold/flu
☐ Infection	☐ Poison ivy/oak	☐ Irritated skin rash
☐ Open cuts, bruises, burns		

Other_____

_____ _____

_____

If you have a specific problem area or an area where you are feeling discomfort, please indicate the area with an X.



I certify that all the answers and statements listed in the Client Health History questionnaire are my own and are true to the best of my knowledge.

_____ _____

Signature Witness