Medical History

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Name _____ Date _____

Address _____ City _____ State _____ Zip _____

Date of Birth _____ Occupation _____

Home Phone _____ Work Phone _____ Cell Phone _____

E-Mail _____

In Case Of Emergency: Name _____ Phone _____

Referred By _____

Primary Physician _____ Date of Last Physical _____

Name of Chiropractor or Acupuncturist _____

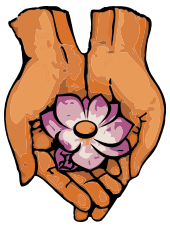
Describe Any Medications You Are Taking _____

What Is Your Previous Massage Experience? _____

What Are Your Goals/Expectations For This Session? _____

Do you have a history of the following?

- ❑ Accidents / Injuries
- ❑ Allergies
- ❑ Anxiety / Depression
- ❑ Arthritis / Bursitis
- ❑ Asthma / Respiratory Conditions
- ❑ Bleeding / Bruising / Clots
- ❑ Broken Bones
- ❑ Cancer / Tumors
- ❑ Carpal Tunnel
- ❑ Colitis / Digestive Conditions
- ❑ Diabetes
- ❑ Excema / Rash
- ❑ Fibromyalgia
- ❑ Headaches / Migraines
- ❑ Heart Attack / Cardiac Conditions
- ❑ Hepatitis / HIV
- ❑ Hernias
- ❑ High / Low Blood Pressure
- ❑ Hypothyroid / Hyperthyroid
- ❑ Kidney / Urinary Conditions
- ❑ Liver / Gall Bladder Conditions
- ❑ Lyme Disease
- ❑ Menopause
- ❑ Numbness / Tingling
- ❑ Pregnancy
- ❑ Rotator Cuff Injuries
- ❑ Sciatica
- ❑ Scoliosis
- ❑ Seizures / Epilepsy
- ❑ Skin Conditions
- ❑ Sprains / Strains
- ❑ Stroke
- ❑ Surgery
- ❑ Varicose Veins / Phlebitis
- ❑ Veterbral Disc Problems
- ❑ Whiplash



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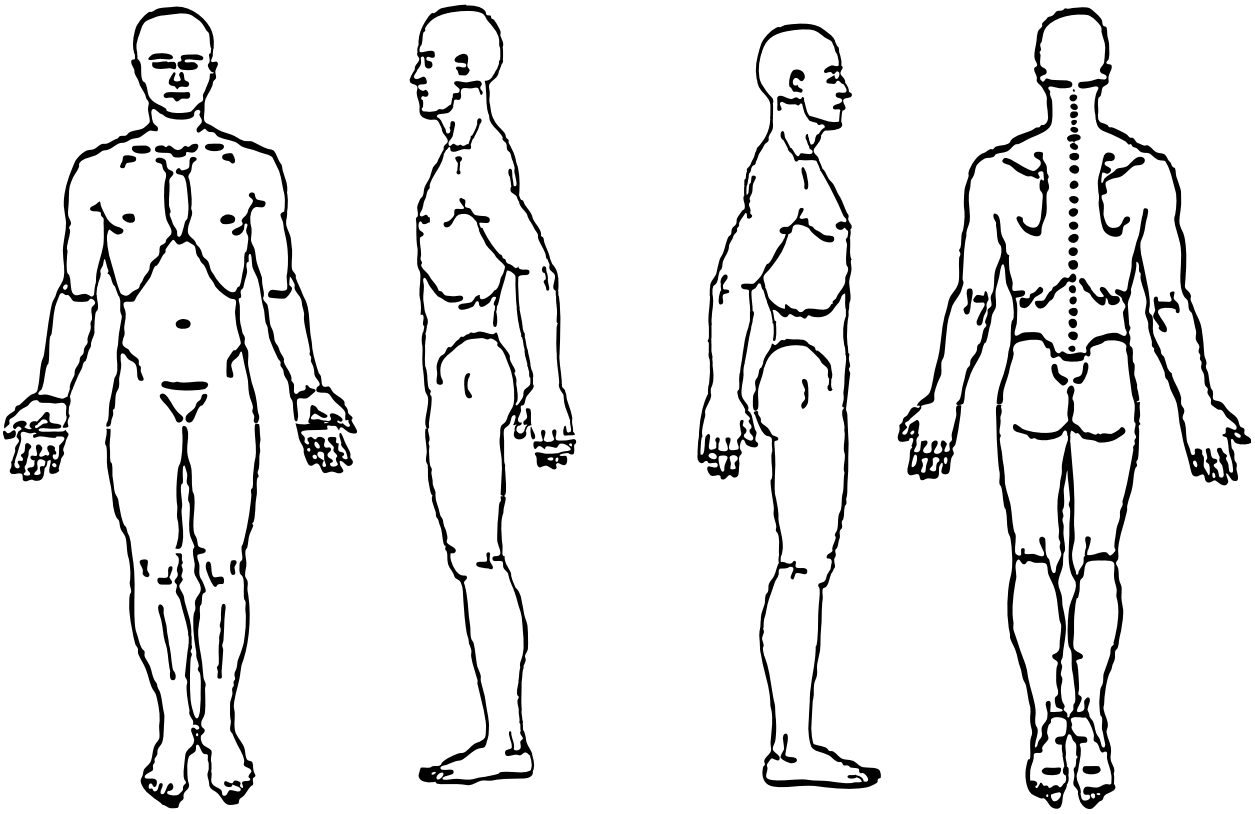
Do you have any of the following today?

❑ Acute Injury	❑ Colds/Flu/Fever	❑ Severe Pain
❑ Headache	❑ Skin Conditon/ Rash	❑ Cuts/Bruises/Burns

Please Indicate Your Level of Use:

	None	Light	Moderate	Heavy
Sugar	❑	❑	❑	❑
Caffeine	❑	❑	❑	❑
Tobacco	❑	❑	❑	❑
Alchohol	❑	❑	❑	❑
Water	❑	❑	❑	❑
Exercise	❑	❑	❑	❑
Stress	❑	❑	❑	❑

Please mark any areas you experience discomfort or tension:



Please read the following and sign below:

- I understand that this massage is not a replacement for medical care and that no diagnosis will be made.
- I am responsible for paying for any appointment cancellation of less than 24 hours.

Signature _____ Date _____