Confidential History

Name: ______________________ Birthdate: __________
Home phone: __________ Work phone: __________ Occupation: __________
Address: ______________________ ______________________
City: ______________________ State: __________ Zip: __________
What is your main objective in getting massage? ______________________
Referred by: ______________________ Have you ever had massage before? __________
Do you have any particular physical problems? ________ Please explain. ______________________
Are you under a physicians care? ________ Who? ______________________
To your knowledge, ARE YOU PREGNANT?? __________ Trimester? __________

Past Medical Information

Have you had any recent (5 years) surgeries? ______ Sprains? ______ Broken bones? ______
Have you ever had any heart problems? ______ Please explain: ______________________
Do you have high or low blood pressure? ______ Have you ever had phlebitis (blood clot)? ______
Please describe any medications or special diet? ______________________
What form of exercise do you get, if any? ______________________
Do you have diabetes? __________ Allergies? __________

Please check any of the following that you have experienced within the past week:

___ Low back pain ___ Neck pain ___ Posture problems
___ Arthritis ___ Swollen joints ___ Bursitis
___ Sore muscles ___ Weak muscles ___ Walking problems
___ Sciatica ___ Abdominal pain ___ Dizziness
___ Flu ___ Headaches ___ Bruise easily
___ Poor circulation ___ Varicose veins ___ Swollen glands
___ Constipation ___ Diarrahea ___ Hemerrhoids

Pain or numbness in: ___ Shoulders ___ Hands ___ Arms ___ Hips ___ Elbows
___ Legs ___ Knees ___ Feet

Do you wear: _____ Contact lenses? _____ Dentures?

Additional notes:

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Over

Indicate areas of pain

In writing please describe pain and any improvements or set backs from last visit. If this is your first visit please explain the cause of pain and how it is effecting you.

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Sign Date