Massage Therapy Health History Questionnaire		
Name:	DOB:	Age:
Address: City: State: Zip:		
Email:	Is this your first massage? Y / N	
Phone#:	Cell Phone#:	
Occupation:	Marital Status:	
Emergency Contact Name:	Emergency contact Phone#:	
Who may we thank for referring you?		
Recent Health Care Providers: Name, Date, Service Provided:		
What are your main concerns/goals for treatment?		
When did you first notice symptoms?		
If you have been diagnosed, what is your diagnosis?		
What kinds of treatments/therapies have you tried?		
Hospitalizations/Surgeries/Accidents: (please list and give approximate date)		
Allergies: *(please include skin allergies such as to nut oils/essential oils)*		
Please list all medications, herbs, and supplements you are currently taking: _____ _____ _____		

Personal History *please check all that apply*			
☐**Insomnia**	☐**Headaches**	☐**Migraines**	☐**Tinnitus**
☐**Easily bruise**	☐**Chest tightness/pain**	☐**High B.P.**	☐**Low B.P.**
☐**Blood clots**	☐**Swelling of feet**	☐**Raynaud's**	☐**Dizziness**
☐**Asthma**	☐**Recent cold/flu**	☐**Bronchitis**	☐**Shortness of breah**
☐**Nausea**	☐ **Constipation**	☐**Diarrhea**	☐**Diverticulitis**
☐**Eczema**	☐**Acne**	☐**Rashes**	☐**Skin infections**
☐**Grind teeth**	☐**Arthritis**	☐**Sciatica**	☐**Disk problems**
☐**Restless leg**	☐**Seizures**	☐**Depression**	☐**Anxiety**
☐**HIV positive**	☐**Mononucleosis**	☐**Diabetes**	☐**Lyme disease**
☐**Hepatitis**	☐**Autoimmune disease**	☐**Cancer**	☐**Eating disorder**
☐**Menstrual problems**	☐ **Hot flashes**	☐**History of sexual abuse**	☐**Prostatitis**
Are you (or could you be) currently pregnant? Y/N *If yes, # of weeks* ____			
Are there any areas of your body that are particularly sensitive or ticklish? Please list _____			
Are there any areas of your body that you prefer not to have worked on? Please list _____			

Informed Consent

Massage Therapy includes the assesment and treatment of the soft tissues and joints of the body using soft tissue manipulation, hydrotherapy, thermal therapy, or application of external herbal preparations. Treatment plans will be discussed in advance with the client and must be agreed upon prior to start. I understand that the massage therapist will not diagnose illness, prescribe medical treatment/pharmaceuticals, or perform spinal manipulation.

I understand that I may occasionally experience side effects from massage therapy. These side effects include but are not limited to the following; transient soreness or pain, bruising, generalized fatigue, gastro-intestinal upset, or skin allergies. To minimize these effects I agree to communicate any discomfort that I may experience during treatment with my massage therapist.

I acknowlege and undertand that the massage therapist must be fully aware of my existing medical conditions. The information I have provided above is true and complete to the best of my knowledge. It is my responsibility to keep the massage therapist updated on my medical history.

This record of consent is required before the first assessment and treatment and will be maintained confidentially in the client file. It may only be released to a third party with prior written consent of the client.

Patient signature (or guardian): _____ Date:_____