Holistic Massotherapy Health History Form

Name _____ Date of initial visit _____

Street Address _____

City/State/Zip:_____

Email address _____

How Did You Find Us? _____

Phone (best # to reach you for scheduling purposes) _____

Date of birth _____ Occupation _____

Sports/Physical Activities/Hobbies _____

The following information will be used to help plan safe and effective massage sessions. Please answer to the best of your knowledge.

1. Have you ever had professional massage before? Yes No If yes, how often?_____

2. Do you have any difficulty lying on your front, back, or side? Yes No

3. Do you have allergic reactions to oils, lotions, ointments, or any other substances put on your skin? Yes No

   If yes, please explain _____

4. Do you wear contact lenses( ) dentures( ) a hearing aid( ) ?

5. Do you sit for long hours at a workstation, computer, or driving? Yes No
   If yes, please describe _____

6. Do you perform any repetitive movement in your work, sports, or hobby? Yes No
   If yes, please describe _____

7. How do you think stress has affected your health? Muscle tension( ) Anxiety( ) Insomnia( ) Irritability( ) Other _____

8. Is there a particular area of the body where you are experiencing tension, stiffness, or discomfort? Yes No
   If yes, please identify _____

9. Do you have any particular goals in mind for this massage session? Yes No
   If yes, please explain _____

In order to plan a massage session that is safe and effective, we need some general information about your medical history.

10. Are you currently under medical supervision? Yes No
    If yes, please explain _____

11. Are you currently taking any medication? Yes No
    If yes, please list _____

12. Please check any condition listed below that applies to you:

____contagious skin conditions	____joint disorders/artificial joints
____open sores or wounds	____rheumatoid arthritis
____bruise easily	____osteoporosis
____recent accident or injury	____epilepsy
____swollen glands	____cancer
____allergies	____diabetes
____heart conditions	____high or low blood pressure
____circulatory disorder	____decreased sensation
____varicose veins	____arteriosclerosis
____phlebitis	____recent surgery
____cystic tumors	____acute/chronic disease

Comments: _____
_____
_____

13. For women: Are you pregnant? Yes No If yes, how many months? _____

14. Is there anything else about your health history that you think would be useful for your massage practitioner to know to plan a safe and effective massage session for you?

_____
_____
_____

I understand that these massage sessions are for general wellness purposes and that I should see a doctor or other appropriate health care provider for diagnosis and treatment of any suspected medical problem. Also, that it is my responsibility to keep my massage practitioner informed of any changes in my health, and any medications that I may begin to take in the future.

Signature _____ Date _____