PERSONAL HEALTH INFORMATION
MASSAGE HISTORY/TREATMENT INFORMATION

Patient Name: ________________________________ Date: ___/____/_____ ☐ Male ☐ Female
E-mail Address__________________________ ____________________ Birthdate: ___/____/_____

Home Address____

____
City State Zip

Home Phone #_________________ Cell Phone #_________________ Work Phone #______________

How did you hear about us?: ☐ Newspaper ☐ Coupon ☐ Current Patient______________________

Occupation________________________________Employer________________________________
Emergency Contact ___________________________ Phone #___________________________________

Have you ever received a professional massage? Yes___ NO___ If yes, frequency________________
Date of last massage____/____/_____ Did you find your massage to be beneficial?___________________

What is your major complaint?____
What aggravates symptoms?________________ What relieves symptoms?_________________________

What results do you want from your massage sessions?

____

____

Prioritize the areas of your body that you would prefer to be massaged:

____

____

Please check that areas of your body that you give permission to receive massage:
☐ Back ☐ Legs ☐ Buttocks ☐ Arms ☐ Abdomen ☐ Chest ☐ Neck ☐ Head ☐ Face
☐ Other____

Typically what type of pressure do you prefer when getting a massage treatment?
☐ Light ☐ Medium ☐ Deep

Are you currently seeing a medical practitioner or chiropractor? Yes___ No___
If so please explain ____

____

List your stress reducers and exercise activities, include frequency ____________________________

____

List current medications, including asprin and ibuprofen, etc: ________________________________

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Females

Are you or could you be pregnant? ☐ Yes ☐ No If yes, how far along?_____________
Please initial the following statement. To the best of my knowledge I am NOT pregnant. I give permission for x-rays to be taken as needed. _______

It is my choice to receive massage therapy. I realize that the treatment is being given for the well being of my body and mind. This included stress reduction, relief form muscular tension, spasm or pain, or for increasing circulation or energy flow. I agree to communicate with my practitioner any time I feel like my well-being is being compromised.
I under stand that massage practitioners do not diagnose illness, disease or any physical or mental disorder; nor do they prescribe medical treatment, pharmaceuticals, pr perform spinal thrust manipulations. I acknowledge that massage is not a substitute for medical examination of diagnosis and that it is recommended that I see my chiropractor or health care provider for that service.
I have stated all medical conditions that I am aware of and will update the massage practitioner of any changes in my health status.

Signature: ____ Date: _______________