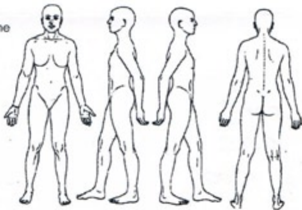
HEALTH HISTORY FORM

Name: ______________________ **Date:** ______________________
Address: ______________________ **Phone number:** ______________________
Date of birth: ______________________ **Email:** ______________________
Physician's name: ______________________ **Allergies:** ______________________
Emergency Contact: ______________________

1. **Do you have any difficulty lying on you back, front, side? YES NO**
2. **Have you had a professional massage before? YES NO**
3. **Do you sit for long periods at a work station, computer, or driving? YES NO**
4. **Are you pregnant? YES NO**
5. **Are you under medical care for any of the following: (circle all pertaining)**

heart conditions	high/low blood pressure	fainting or dizziness
varicose veins	phlebitis/circulatory problems	headaches or migraine
neck injury	back injury	jaw or ear pain
osteoporosis	rheumatoid arthritis	osteoarthritis
cancer	kidney disease	skin conditions
diabetes	asthma/respiratory	fibromyalgia
Crohn's disease	pelvic inflammatory disease	epilepsy
nervous disorders	whiplash	other: ______________

Circle any specific areas you would like the massage therapist to concentrate on during the session:



Have you had any surgery in the past? If yes, for what? ______________________

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Have you had any fractures/sprains/injuries in the past? If yes, when/where? ______________________

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Have you had any serious illnesses in the past? If yes, what/when? ______________________

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What relieves your pain? (Cold, heat, rest, pressure) ______________________
What aggravates your pain? (Cold, heat, sitting, standing,) ______________________