balanceYoga
by amanda

Massage Therapy Client Medical History Form

Name: ____

Phone: ________________________________ **E-mail:**_______________________________

Address: ____

City/State/Zip: ____

Date of Birth: __________ **Gender:** _________ **Occupation:** _____________________________

Referred by: ___________________________ **Physician:** ______________________________

Best method/time of day to contact you:____

Emergency Contact Name/Number:____

Have you ever received a massage before? (circle one): Yes | No

Today's primary reason for massage: ____

Check any of the following that apply to your current health:

___ Headaches/migraines ___ Chronic pain ___ Fatigue ___ Heart conditions

___ Circulatory conditions ___ Tension/stress ___ Depression ___ Muscle or joint pain

___ Numbness or tingling ___ Cancer ___ Arthritis ___ Diabetes

___ Pregnancy ___ Blood clots ___ Fever ___ Allergies/Sensitivity

___ High/low Blood Pressure ___ Sprains/Strains ___ Infectious dis. ___ Other injuries/illness

Explain items noted above: ____

____

Current medications, including herbs & supplements: ____________________________________

____

Surgeries, accidents, and/or major illnesses: ____

____

Signature: ___________________________________ **Date:** ___________________________

Thank you! Please note that all information on this form will be kept confidential.