General Health History Form

Date: _____

The information provided in these forms are confidential and may only be shared with your written consent.

Name_____Date of birth _____

Address_____

–

street

_____

city ***state*** ***zip code***

Home Phone_____ Cell Phone_____

Email Address_____

How were you referred? _____

Please describe why you are seeking Massage Therapy:

_____

_____

_____

_____

Have you received therapeutic massage before? _____ If so, how frequently?

Please describe:_____

What is your occupation? How is your body mostly used while working?

_____

_____

Client initials_____

Please describe your exercise habits and other physical activities:

_____

_____

Please describe your self-care and stress-reduction activities:

_____

_____

Please circle any painful or tense areas of the body that you are aware of:

head/face ***chest*** ***arms/hands*** ***neck*** ***abdomen*** ***hips***

upper back ***mid-back*** ***legs/feet*** ***shoulders*** ***lower back*** ***other:***

How long have you been aware of these areas? Please describe:

_____

_____

Please list any diagnosed health conditions that are being monitored by a physician, or another provider: _____

_____

_____

Please list any medications you are currently taking, and what they are for:

_____

_____

Please describe any previous or present injuries (include the date):

_____

_____

_____

Please describe any previous surgeries (include the date):

_____

_____

Do you have any other history of trauma you would like to share?

_____

_____

Client initials_____

Are you currently experiencing any of the following? Please mark all that apply:

___Infection ___Swelling ___Numbness/altered sensation ___Skin condition

___Pain(mild__moderate__severe__)

Please describe:_____

_____

_____

Please circle any of the following health issues that you have experienced:

allergies	heart attack	migraines/headaches
arthritis	heart disease	osteoporosis
asthma	hemophilia	phlebitis/thrombosis
blood clot	hepatitis	repetitive strain injury
cancer	herpes simplex	respiratory conditions
carpal tunnel syndrome	high blood pressure	sciatica
communicable diseases	hypertension	stroke
congestive heart failure	hypoglycemia	thyroid disorders
diabetes	immune system condition	tumors
disc problems	irritable bowel syndrome	varicose veins
fibromyalgia	insomnia	whiplash
gastrointestinal disorders	kidney, urinary, or liver problems	other_____

Please describe any of the above circled health issues:

_____

_____

_____

Statement of Informed Consent

I understand that my consent is essential in receiving therapeutic touch and that I have complete agency in setting the boundaries for my body in these bodywork sessions. I understand that massage therapy is not a substitute for medical examination, nor does the massage practitioner diagnose illness, disease, or any physical or mental condition. Furthermore, it is recommended that I see a primary health care provider for that purpose. I have provided all of my known medical information and will inform the therapist of any new information I become aware of while in her care. If I experience any pain or discomfort during the session, I will communicate with the therapist so that the techniques may be adjusted to my level of comfort. I hereby give consent to receive therapeutic massage for the purpose of reducing stress, relieving muscular tension, spasm or pain, increasing circulation and energy flow, and facilitating healing from injury or trauma.

Client signature_____Date_____

Emergency Contact_____

Phone number_____Relationship_____

Client initials_____

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