



Welcome

Medical History

Name _____ Date _____

Address _____ City/Town _____

State _____ Zip Code _____ Phone# _____ Cell# _____

E-mail _____ Referred by _____

Date of Birth _____ Occupation _____

Primary Physician _____ Date of last Physical _____

Medications (use other side if necessary) _____

What is your previous massage experience?

What is your reason for choosing massage? What results do you expect from this treatment?

What is your exercise routine?

Please circle any of the following that pertain to you: (please describe further on side)

- | | | |
|-------------------------|-----------------------------|--------------------------|
| Allergies | Depression | Phlebitis/Blood |
| Arthritis | Diabetes | Pins/Pacemaker |
| Anxiety | Digestion Problems | Pregnancy |
| Anemia | Dizziness/Fainting | Psychiatric |
| Asthma | Endocrine Issues | Recent Surgery |
| Athlete's Foot | Fatigue | Respiratory |
| Bleeding/Bruising | Headaches | Seizures/Epilepsy |
| Blood Pressure Problems | Hepatitis | Sinus Problems |
| Bursitis | Hernia | Skin Conditions |
| Cancer | Joint Problems | Smoker |
| Cardiac Issues | Kidney/Urinary | Stress |
| Circulation Problem | Liver/Gall Bladder Neuritis | Ulcers |
| Cold Sweats | Muscle Strain/Sprain | Varicose Veins |
| Contact Lenses | Osteoporosis | Vertebral/ Disc Problems |

Other (include any other conditions, syndromes, recent accidents and any information pertinent to your health status):

Please explain any conditions that you circled above:

(turn over)

