



Myokinematic massage therapy

CONFIDENTIAL HEALTH HISTORY FORM

Name: _____

Address: _____

_____ Postal Code: _____

Phone: Home (____) _____

Work (____) _____

Cell (____) _____

Gender: ___M___F Date of Birth: _____ Occupation: _____

Day / Month / Year

E-mail: _____

Emergency Contact Name: _____ Phone: (____) _____

Physician Name: _____ Phone: (____) _____

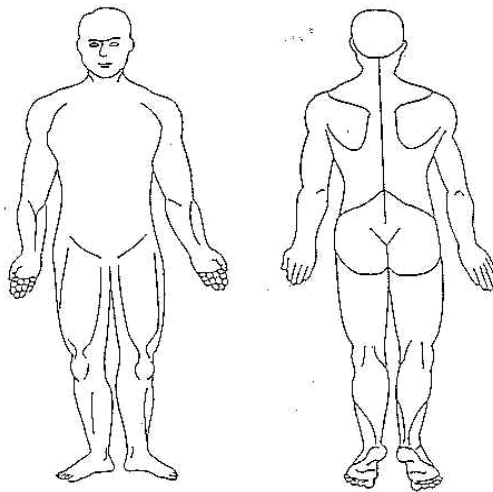
The following information will be used to help plan safe and effective massage sessions. Please answer the questions to the best of your knowledge.

Have you received massage therapy before: ___YES___ NO

Primary reason you are seeking massage therapy:

When did you first notice this issue?

Please indicate on this diagram where pain or discomfort is occurring:



Any additional comments: _____

Please indicate (✓) conditions you are experiencing or have experienced:

High Blood Pressure	Asthma	Arthritis	Muscle/Joint Issues:
Low Blood Pressure	Shortness of Breath	Osteoporosis	Neck
Heart Attack	Emphysema	Bursitis	Back
Heart Disease	Bronchitis	Sprain	Shoulder
Stroke/CVA	Epilepsy/ Seizures	Strain	Elbow/Wrist/Hand
Congestive Heart Failure	HIV/ AIDS	Fracture	Hip
Anemia	Cancer	Numbness/ Tingling	Knee
Hemophilia	Tumors	Dizziness/ Vertigo	Ankle/Foot
Phlebitis/ Varicose Veins	Edema/ Inflammation	Headaches/ Migraines	
Diabetes	Allergies/ Sensitivities	Insomnia/ Sleep Difficulties	
Digestive Conditions	Skin Conditions	Anxiety	Women only: Pregnancy
Vision or Hearing Loss	Poor Circulation	Excessive Stress	
Pins/Screws/Artificial Joints	Artherosclerosis		

List any other medical conditions not listed:

Are you presently taking any medications (prescribed or over the counter)? ____ YES ____ NO
If yes, please list medication(s) and the condition for which it is being used.

Are you seeing any other health care professionals or receiving any other medical treatment?

Briefly list any surgeries or injuries you have experienced including the date:

What type of physical activity, exercise, stretching do you do? _____

How many times per week? _____

Is there anything else about your health history that would be important for the massage therapist to know?

I, _____ (print name) understand that the massage I receive is provided for therapeutic purposes. If I experience any pain or discomfort during this session, I will immediately inform the therapist so that the pressure and/or technique may be adjusted to my level of comfort. I further understand that massage should not be construed as a substitute for medical examination, diagnosis, or treatment and that I should see a physician for any mental or physical ailment that I am aware of. I understand that massage therapists are not qualified to perform spinal or skeletal adjustments, or prescribe and that nothing said in the course of the session given should be construed as such. Due to the fact that massage should not be performed under certain medical conditions, I affirm that I have stated all my known medical conditions, and answered all questions honestly. It is my responsibility to keep the therapist updated as to any changes in my medical profile and understand that there shall be no liability on the therapist's part should I fail to do so.

I understand that payment is expected at the time of the appointment unless previous arrangements have been made, and that if I fail to cancel an appointment 24 hours in advance, I will be charged for the missed appointment.

Signature: _____

Date: _____

Updated: _____

Updated: _____