



# Massage Therapy Medical History

Name: \_\_\_\_\_ Date: \_\_\_\_\_

Address: \_\_\_\_\_

Email: \_\_\_\_\_ Cell # for confirmations: \_\_\_\_\_

DOB: \_\_\_\_\_ Occupation: \_\_\_\_\_

How did you hear about us or who can we thank for your visit today? \_\_\_\_\_

Have you had massage therapy before?  Yes  No If yes, when was your last massage? \_\_\_\_\_

**For Women:** Are you pregnant?  Yes  No If yes, how many weeks? \_\_\_\_\_

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## Medical Information:

List accidents/injuries, hospitalizations, and surgeries: When they occurred, treatment received and any lingering effects.

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Chronic ongoing pain, and do activities affect the pain?  Yes  No

If Yes, please describe and care or treatment you received.

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Please list all prescribed and over the counter drugs, supplements and/or herbs taken and what they are for.

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**History** (helps determines treatment options)

**Musculoskeletal**

- Osteoporosis
- Arthritis
- Hypothyroidism
- Fibromyalgia
- Chronic Fatigue
- Gout in \_\_\_\_\_
- Bursitis
- Plantar Fasciitis
- Cysts/Lipomas
- TMJ
- Chronic Headaches
- Tendonitis
- Whiplash
- Strain/Sprains
- Chronic pain in:
  - Neck
  - Back
  - Hips
  - Arms
  - Legs
  - Shoulder
  - Wrist/Hand
- On computer more than 2 hrs/day  
No. of hrs: \_\_\_\_\_

**Respiratory**

- Breathing Problems
- Sinusitis

**Digestive**

- IBS
- Crone's disease
- Constipation
- Diarrhea

**Circulatory**

- Heart problems: \_\_\_\_\_
- Stroke
- Palpitations
- Mitral valve prolapsed
- Anemia
- Hemophilia
- Hypertension
- Low Blood Pressure
- Peripheral Artery Disease
- Raynaud's Disease
- Varicose veins
- Blood clots/Phlebitis

**Skin**

- Fungal infections
- Athlete's Foot
- Impetigo
- Eczema/Dermatitis
- Psoriasis
- Easily irritated skin
- Other: \_\_\_\_\_

**Nervous System**

- Dizziness
- ALS
- Multiple Sclerosis
- Parkinson's disease
- Bell's Palsy
- Neuritis
- Spinal cord injury
- Trigeminal Neuralgia
- Seizures/Epilepsy

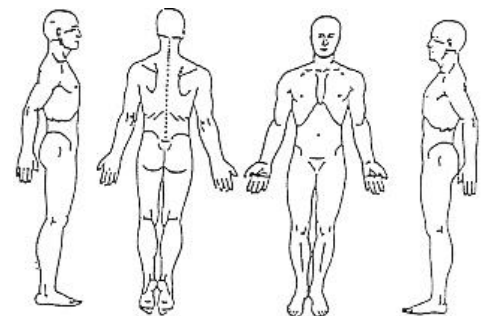
**Other**

- Diabetes
- Cancer
- Kidney disease
- Hepatitis
- HIV/AIDS
- Lupus
- Postoperative: \_\_\_\_\_
- Cystitis
- High stress
- Grieving
- Anxiety/Panic attacks
- PMS/Menopause difficulties
- Poor sleep/Insomnia
- Allergies affecting: \_\_\_\_\_
- Other: \_\_\_\_\_

Is there any particular area of the body where you are experiencing tension, stiffness or other discomfort?  Yes  No

Explain and/or circle on diagram: \_\_\_\_\_

Are you interested in learning how you can have long term wellness results using essential oil?  Yes  No



The above information is accurate. I understand that License Massage Therapists do not diagnose disease or prescribe drugs and that they are not a substitute for medical care. I agree to alert my practitioner of any physical/emotional changes as they occur.

\_\_\_\_\_  
Client signature

\_\_\_\_\_  
if under 18; Parent signature

\_\_\_\_\_  
Date