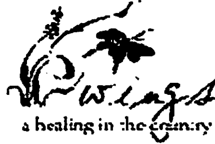


Health History Form

Date ______________

Client Name ____

Address ____

City ____________ **State** ___________ **Zip Code** ________

Telephone Numbers:

Home (___) ____________________

Work (___) ____________________ **Ext:** ___________

Cell (___) ____________________

Email ____

Date of Birth ____________________ **Gender: Male** ________ **Female:** ________

How Were You Referred to Our Office? ______________________________

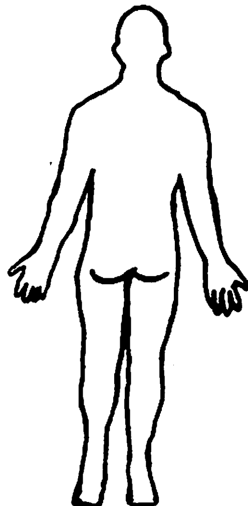
Have You Previously Received Professional Massage? Yes _________ **No** ________

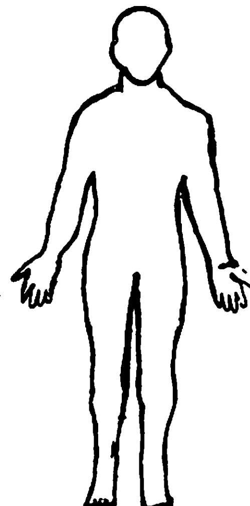
Reason for Massage ____

Describe Any Areas of Pain or Discomfort ______________________________

____

Please Mark Below Any Areas of Pain or Discomfort





What is Your Occupation?___________________________________

Rate Your Stress Level: Low _____ _____ _____ _____ _____ **High**

Describe Your Exercise Habits: ______________________________

Do You Eat a Balanced Diet: Yes _______ **No** _______

Comments: ____

Rate Your Normal Consumption of the Following:

	Heavy	Moderate	Light	None
Alcohol	_____	_____	_____	_____
Tobacco	_____	_____	_____	_____
Sugar	_____	_____	_____	_____
Caffeine	_____	_____	_____	_____

Describe Your Overall Heal th:

____

Are You Pregnant: _______ **Due Date:** __________

Have You Had Surgery in the Last 2 Years : Yes________ **No** __________

Describe: _________

Do You Have A History of Any Broken Bones, Major Sprains, or Dislocations:

____

Physician's Name: ______________________ **Date of Last Exam:** ________

If You Are Under a Doctors Care, Please Explain:

____

List Any Medications We Need to Be Aware Of: ______________________

____

Mark Any Symptoms or Conditions You May Have:

____Abdominal Pain	____Allergies	_____Chest Pain
____Blood Clots	____Carpal Tunnel	_____Contagious Diseases
____Constipation	____Depression	_____Digestive Problems
____Diabetes	____Dizziness	_____Heart Disease
____Circulatory Problems	____Fatigue	_____Joint Disease
____High Blood Pressure	____Insomnia	_____Muscular Injuries
____Low Blood Pressure	____Sinusitis	_____Respiratory Disease
____Migraine Headaches	____Skin Conditions	____Arthritis _____Other

Do You have Any History of Physical or Emotional Trauma? No___**Yes**____

If Yes, Please Explain:____

Client Signature _________________________________ **Date** ___________

Therapist Signature ______________________________ **Date** __________