**Lynn's Massage Therapy**

**Confidential Health History**

**Personal Information**

Name: _____Male ☐ Female ☐

Address: _____

City: _____ State: _____ Zip: _____

Date of Birth: _____ Occupation: _____

*Reminders will be sent Via Text Message/E-mail*

E-mail: _____Phone #: _____

In case we need to contact you for your appointment what is the best way to reach you. (Circle One)

☐ Phone Call ☐ Text Message ☐ E-mail

***The following information will be used to help plan safe and effective massage sessions.***

***Please answer the questions to the best of your knowledge.***

Date of Initial Visit: _____ Referred By: _____

Why would you say you are seeking a professional massage?

☐ Stress ☐ Relaxation ☐ Physical Problem ☐ Gift Certificate ☐ Other

Have you had a professional massage before? Yes ☐ No ☐ If Yes, How long ago?_____

What is your preferred level of pressure? ☐ Mild ☐ Moderate ☐ Firm ☐ Ouch

Do you have any difficulty lying on your front, back, or side? Yes ____ No ___

If yes, please explain:_____

Do you have any allergies to oils, lotions, or ointments? Yes ☐ No ☐

If yes, please explain:_____

Do you have sensitive skin? Yes ☐ No ☐

Are you wearing: contact lenses ☐ dentures ☐ a hearing aid ☐

Do you sit for long hours at a workstation, computer, or driving? Yes ☐ No ☐

If yes, please describe:_____

Do you perform any repetitive movement in your work, sports, or hobby? Yes ____ No ____

If yes, please describe: _____

Do you experience stress in your work, family, or other aspect of your life? Yes ____ No _____

If yes, how do you think it has affected your health?

Muscle tension ☐ anxiety ☐ insomnia ☐ irritability ☐ other _____

Is there a particular area of the body where you are experiencing tension, stiffness, pain or other discomfort? Yes ☐ No ☐ If yes, please identify:_____

Do you have any particular goals in mind for this massage session? Yes ☐ No ☐

If yes, please explain:_____

## Medical History

***In order to plan a massage session that is safe and effective, I need some general information about your medical history.***

Are you currently under medical supervision? Yes ☐ No ☐

If yes, please explain: _____

Do you see a chiropractor? Yes ☐ No ☐ If yes, how often? _____

Are you currently taking any medication? Yes ☐ No ☐

If yes, please list: _____

_____

**Please check any condition listed below that applies to you:**

**HEAD**
- ☐ TMJ
- ☐ Headaches
- ☐ Sensitivity to Light
- ☐ Sinus Trouble

**NECK**
- ☐ Popping/Grinding
- ☐ Pain with Movement
- ☐ Stiff Neck

**SHOULDERS** - *Can't raise arms*:
- ☐ Above Shoulders
- ☐ Over the Head

**ARMS & HAND**
- ☐ Numbness or Tingling
- ☐ Cold Hands
- ☐ Loss of Grip Strength
- ☐ Shooting Pain

**BACK**
- ☐ Upper Back Pain
- ☐ Mid Back Pain
- ☐ Spinal Issue
- ☐ Disk Problem

**LOW BACK** *Pain is Worse When*
- ☐ Lifting
- ☐ Sitting
- ☐ Lying Down
- ☐ Bending
- ☐ Coughing
- ☐ Working

**HIPS, LEGS & FEET**
- ☐ Leg or Foot Cramp
- ☐ Cold Feet
- ☐ Swollen Ankles
- ☐ Shooting Pain
- ☐ Hip Replacement R or L
- ☐ Knee Replacement R or L
- ☐ Ticklish Feet

**FEMALES**
- ☐ Pregnant: # *of Months*
- ☐ Post-Partum
- ☐ Menstrual Pain/Cramping

**TOTAL BODY**
- ☐ Allergies
- ☐ Skin Allergies/Problems
- ☐ Thyroid Trouble
- ☐ Strain/Sprain
- ☐ Arthritis
- ☐ Bursitis
- ☐ High Blood Pressure
- ☐ Low Blood Pressure
- ☐ Bruise Easily
- ☐ Cardiac/Circulatory Issue
- ☐ Chest Pain
- ☐ Stroke/Closed Head Injury
- ☐ Diabetes (Insulin or Non-Insulin Dependent)
- ☐ Sciatica
- ☐ Osteoporosis
- ☐ Inflammation: *Where?* _____
- ☐ Dizziness or Fainting
- ☐ Numbness or Tingling *Where?* _____
- ☐ Infectious Condition or Disease *Where?* _____
- ☐ Seizures/Epilepsy
- ☐ Cancer
- ☐ Whiplash
- ☐ Varicose Veins/Artery Issue

Please explain any condition that you have marked on the previous page:

_____

_____

Is there anything else about your health history that you think would be useful for your massage practitioner to know to plan a safe and effective massage session for you?

_____

_____

***Draping will be used during the session – only the area being worked on will be uncovered.***

***Informed written consent must be provided by parent or legal guardian for any client under the age of 17.***

I, _____ (print name) hereby consent to bodywork with the understanding that massage therapy is provided for the purpose of relaxation, relief of muscular tension or for increasing circulation and energy flow. If I experience any pain or discomfort during this massage session, I will immediately inform the therapist so that the pressure and/or strokes 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 physician, chiropractor or other qualified medical specialist 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, diagnose, prescribe, or treat any physical or mental illness, and that nothing said in the course of the session given should be construed as such. Because 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. I agree 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 also understand that any illicit or sexually suggestive remarks or advances made by me will result in immediate termination of the session and I will still be liable for FULL PAYMENT of scheduled appointment**. I also understand that the License Massage Therapy reserves the right to refuse to perform massage on anyone whom he/she deems to have a condition for which massage is contraindicated.

Signature of client _____ Date _____