



Medical History

Name _____ Date _____
 Address _____ City _____ State _____ Zip Code _____
 Home Phone _____ Work Phone _____
 Date of Birth _____ Occupation _____
 Referred By _____ Physician _____

Email Address _____

Have you received massage therapy before? Yes No
 Do you currently or have you ever seen a Chiropractor? Yes No
 Are you currently pregnant? Yes No

Please list any medications taken regularly _____

What do you expect to benefit from massage? Stress Reduction Relaxation
 Decrease Pain Increased Range of Motion
 Other _____

Are there any areas of your body that are especially sensitive? _____

Do you exercise regularly? Yes No
 Do you smoke? Yes No
 Have you had any major illnesses or operations? Yes No

Please Circle any of the following that you currently have:

Diabetes	Arthritis	Hernia	Varicose Veins	Stomach Ulcers
Cancer	Epilepsy	Dizziness	Depression	Skin Problems
Headaches	Hemophilia	Phlebitis	Allergies	Pins/ Screws
Pacemaker	Heart Disease	Contact Lenses	Hair Piece/Wig	High Blood Pressure
Musculoskeletal Problems	Sciatica	Plantar Fasciitis	Low Blood Pressure	

Any other concerns? (neck, back problems, tendonitis, sprain, strains, broken bones, etc)

Signature _____

