

Medical History

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Name _____

Address _____

City _____

State _____

Zip _____

Date of Birth _____

Occupation _____

Home Phone _____

Work Phone _____

Cell Phone _____

E-Mail _____

In Case Of Emergency: Name _____

Phone _____

Referred By _____

Primary Physician _____

Date of Last Physical _____

Name of Chiropractor or Acupuncturist _____

Describe Any Medications You Are Taking _____

What Is Your Previous Massage Experience? _____

What Are Your Goals/Expectations For This Session? _____

Do you have a history of the following?

- | | | |
|---|---|---|
| <input type="checkbox"/> Accidents / Injuries | <input type="checkbox"/> Headaches / Migraines | <input type="checkbox"/> Sciatica |
| <input type="checkbox"/> Allergies | <input type="checkbox"/> Heart Attack /
Cardiac Conditions | <input type="checkbox"/> Scoliosis |
| <input type="checkbox"/> Anxiety / Depression | <input type="checkbox"/> Hepatitis / HIV | <input type="checkbox"/> Seizures / Epilepsy |
| <input type="checkbox"/> Arthritis / Bursitis | <input type="checkbox"/> Hernias | <input type="checkbox"/> Skin Conditions |
| <input type="checkbox"/> Asthma /
Respiratory Conditions | <input type="checkbox"/> High / Low Blood Pressure | <input type="checkbox"/> Sprains / Strains |
| <input type="checkbox"/> Bleeding / Bruising / Clots | <input type="checkbox"/> Kidney / Urinary Conditions | <input type="checkbox"/> Stroke |
| <input type="checkbox"/> Broken Bones | <input type="checkbox"/> Liver / Gall Bladder
Conditions | <input type="checkbox"/> Surgery |
| <input type="checkbox"/> Cancer / Tumors | <input type="checkbox"/> Lyme Disease | <input type="checkbox"/> Varicose Veins / Phlebitis |
| <input type="checkbox"/> Carpal Tunnel | <input type="checkbox"/> Menopause | <input type="checkbox"/> Veterbral /
Disc Problems |
| <input type="checkbox"/> Colitis / Digestive Conditions | <input type="checkbox"/> Numbness / Tingling | <input type="checkbox"/> Whiplash |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Pregnancy | |
| <input type="checkbox"/> Excema / Rash | <input type="checkbox"/> Rotator Cuff Injuries | |
| <input type="checkbox"/> Fibromyalgia | | |

continued on other side



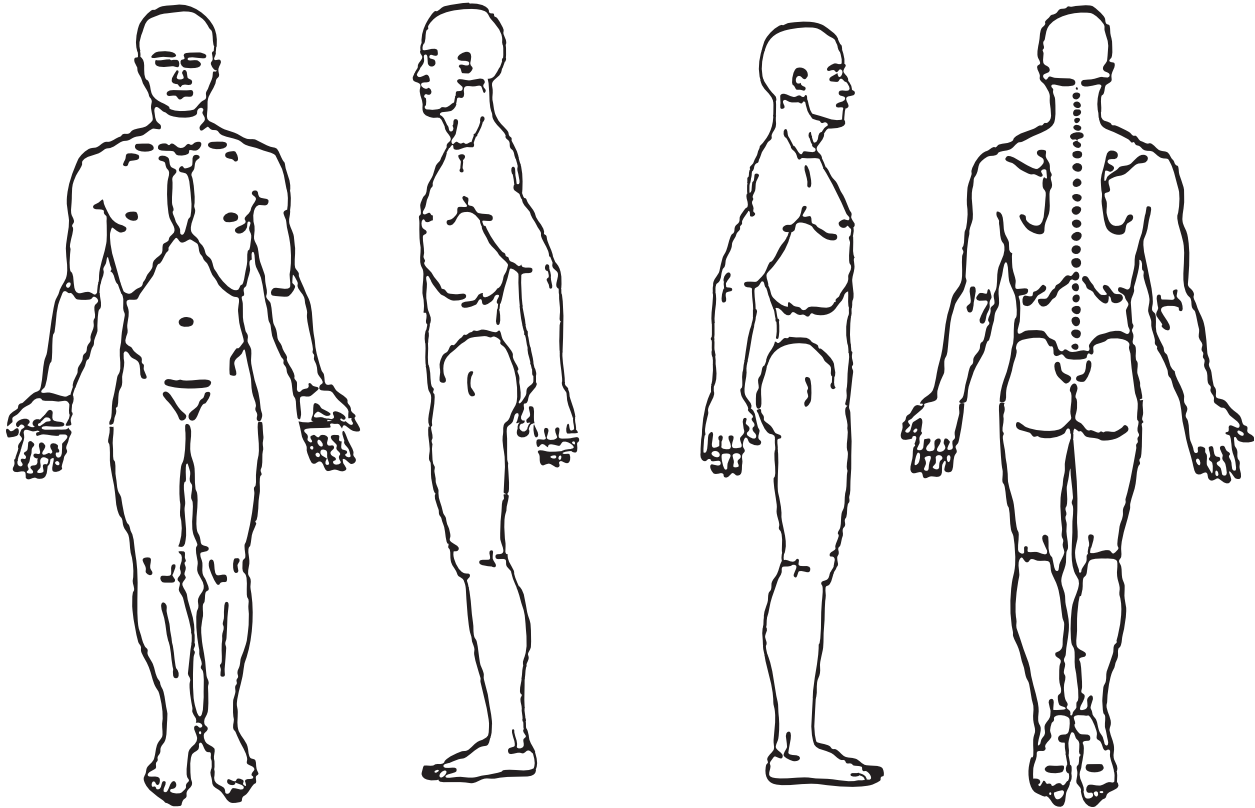
Do you have any of the following today?

- | | | |
|---------------------------------------|---|---|
| <input type="checkbox"/> Acute Injury | <input type="checkbox"/> Colds/Flu/Fever | <input type="checkbox"/> Severe Pain |
| <input type="checkbox"/> Headache | <input type="checkbox"/> Skin Condition/ Rash | <input type="checkbox"/> Cuts/Bruises/Burns |

Please Indicate Your Level of Use:

	<u>None</u>	<u>Light</u>	<u>Moderate</u>	<u>Heavy</u>
Sugar	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Caffeine	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Tobacco	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Alcohol	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Water	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Exercise	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Stress	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Please mark any areas you experience discomfort or tension:



Please read the following and sign below:

- I understand that this massage is not a replacement for medical care and that no diagnosis will be made.
- I am responsible for paying for any appointment cancellation of less than 24 hours.

Signature

Date