Health History for Massage Therapy Treatment

Name _____ Date of initial visit _____

Address _____ Phone _____

City, State, Zip _____ Date of birth _____

Referred By _____ Email _____

Phone number for receiving text messages _____

1. Have you had massage therapy before? Yes No

2. For women: Are you pregnant? Yes No
   If yes, how many months? _____

3. Do you have any difficulty lying on your front, back, or side? Yes No
   If yes, please explain _____

4. Do you have allergic reactions to oils, lotions, ointments, liniments, or other substances put on your skin? Yes No
   If yes, please explain _____

5. Do you wear contact lenses ☐ dentures ☐ a hearing aid ☐?

6. Do you sit for long hours at a workstation, computer, or driving? Yes No
   If yes, please describe _____

7. Do you perform any repetitive movement in your work, sports, or hobby? Yes No
   If yes, please describe _____

8. Do you experience stress in your work, family, or other aspect of your life? Yes No
   How would you describe your stress level?
   Low Medium High Very high
   If high, how do you think stress has effected your health?
   muscle tension ☐ anxiety ☐ insomnia ☐ irritability ☐ other _____

9. Is there a particular area of the body where you are experiencing tension, stiffness, or other discomfort? (see body map) Yes No
   If yes, please identify _____

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

10. Are you currently under medical supervision? Yes No
    If yes, please explain _____

11. Are you currently taking any medication? Yes No
    If yes, please list _____

13. Please check any condition listed below that applies to you:

_____Skin condition (e.g., acne, rash, skin cancer, allergy, easy bruising, contagious condition)

_____Allergies

_____Past accident, injury, or surgery (e.g., whiplash, sprain, broken bone, deep bruise)

_____Muscular problems (e.g., tension, cramping, chronic soreness)

_____Joint problems (e.g., osteoarthritis, rheumatoid arthritis, gout, hypermobile joints, recent dislocation)

_____Lymphatic condition (e.g., swollen glands, nodes removed, lymphoma, lymphedema)

_____Circulatory or blood conditions (e.g., atherosclerosis, varicose veins, phlebitis, arrhythmias, high or low blood pressure, heart disease, recent heart attack or stroke, blood clots, anemia)

_____Neurologic condition (e.g., numbness or tingling in any area of the body, sciatica, damage from stroke, epilepsy, multiple sclerosis, cerebral palsy)

_____Digestive conditions (e.g., ulcers)

_____Immune system conditions (e.g., chronic fatigue, HIV/AIDS)

_____Skeletal conditions (e.g., osteoporosis, bone cancer, spinal injury)

_____Headaches (e.g., tension, PMS, migraines)

_____Cancer

_____Emotional difficulties (e.g., depression, anxiety, panic attacks, eating disorder, psychotic episodes). Are you currently seeing a psychotherapist for this condition? Yes No

_____Previous surgery, disease, or other medical condition that may be affecting you now (e.g., polio, previous heart attack or stroke, previously broken bones, abdominal aortic aneurysm)

_____Elective surgery or procedures

Comments:

_____

_____

_____

14. 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?

_____

_____

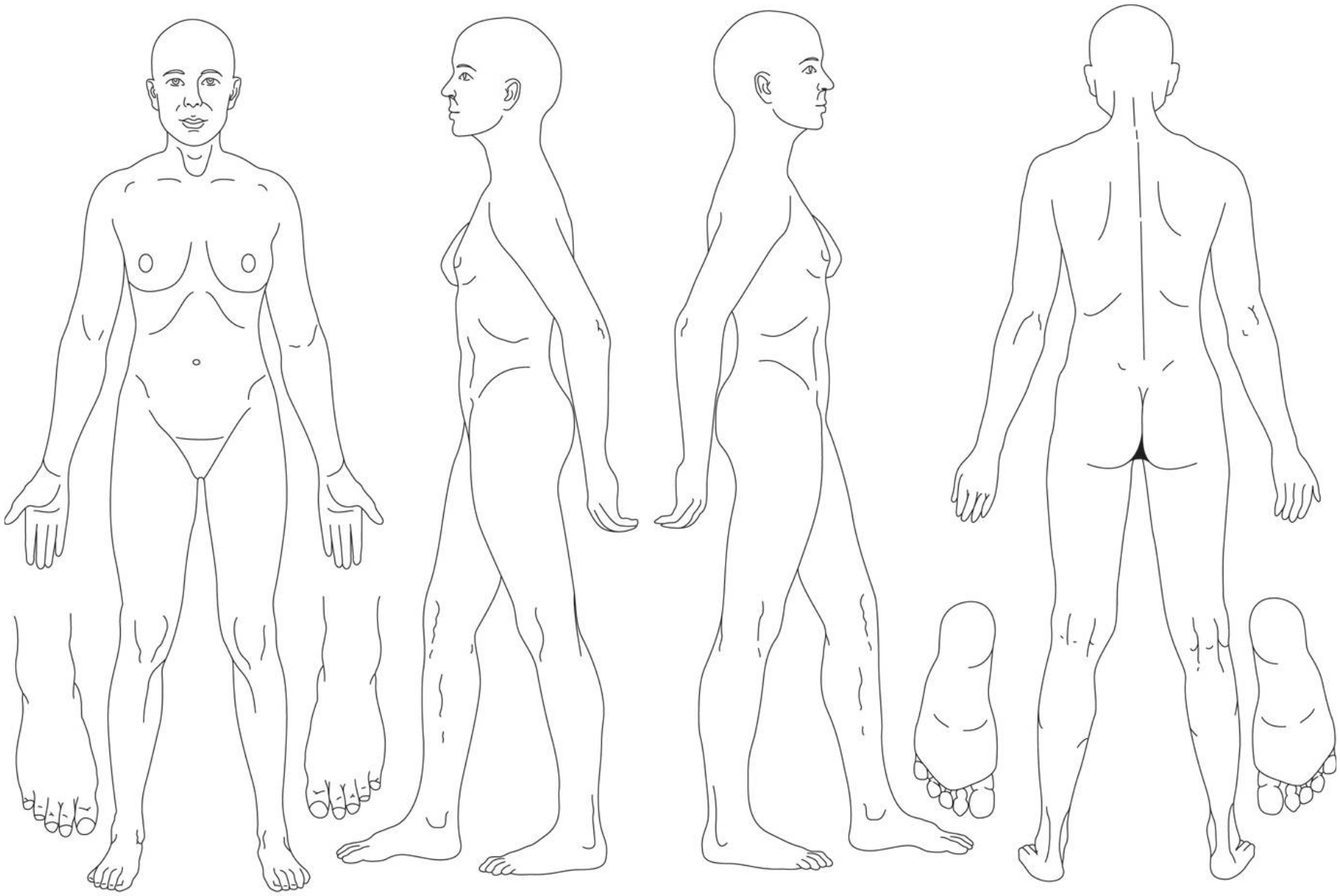
_____

15. Has your physician or other health care provider recommended massage for any of the conditions listed above? Yes No
If yes, please explain _____

16. Do you have any particular goals in mind for this massage session related to any of the conditions mentioned above? Yes No
If yes, please explain _____

I understand that I should see a doctor or other appropriate health care provider for diagnosis and treatment of any suspected medical problem. It may be beneficial for my massage practitioner to speak to my doctor about my medical condition to determine how massage may help the healing process, and to avoid worsening the condition. I will be asked for permission to contact my doctor, if the massage practitioner thinks that it might be useful. I also understand that it is my responsibility to keep my massage practitioner informed of any changes in my health, and any medications that I may begin to take in the future.

Signature _____ Date _____



Body map to show areas of pain

General Agreement and Consent

I, _____ understand that the massage therapy given to me by James Mally is for the purpose of general health and wellness, relaxation, improved circulation, pain management, and other effects supported by experience and research. Massage therapy is performed here within the scope of practice of massage therapists in this state.

I understand that massage therapists do not diagnosis medical conditions, nor do they prescribe medical treatments or medications, nor do they perform spinal manipulation or chiropractic adjustments.

I understand that massage therapy is not a substitute for examination by a medical provider, and that it is recommended that I seek medical attention first for any illness, injury, or disorder that I might have.

I understand that massage therapy can be a valuable complement to health care provided by medical doctors, chiropractic physicians, naturopathic physicians, practitioners of traditional Chinese medicine, and psychiatrists and psychologists. I agree to keep my massage therapist informed of any medical treatment I am receiving with the understanding that it may impact the massage therapy I receive.

I have stated all my known medical conditions, treatments, and medications, and I agree to keep the massage therapist updated on any changes.

I understand that although Dr. Mally was formerly licensed as a Naturopathic Doctor in California, I am seeing him in his capacity as a massage therapist. I understand he is not a chiropractor and does not perform chiropractic adjustments.

Appointments canceled within 24 hours of the scheduled time will be billed at 50% of the standard rate.

My signature below confirms my agreement to the general policies, privacy policy, and consent statement above.

Name _____ Date _____