



Massage Therapy Patient History Form
CONFIDENTIAL INFORMATION

Name:

Email:

Address:

Phone:

Occupation:

Date of Birth:

Insurance Information:

Have you ever received massage therapy?

—Yes —No if yes, please list the type of massage experienced (i.e. Swedish):

Are you currently taking any medications?

—Yes —No if yes, please list name and reason for medications:

Are you currently seeing a healthcare professional?

—Yes —No If yes, please list names and reason/treatment:

Please circle conditions that have affected your health recently or in the past:

arthritis, diabetes, blood clots, broken/dislocated bones, bruise easily, cancer, chronic pain, constipation/diarrhea, auto-immune condition*, hepatitis (A, B, C, other), skin conditions, stroke, surgery, TMJ disorder, depression, panic disorder, other psych, joint pain, diverticulitis, headaches, heart conditions, back problems, high blood pressure, insomnia, muscle strain/sprain, pregnancy, scoliosis, seizures, whiplash, chemical dependency (alcohol, drugs)
(*AIDS, fibromyalgia, chronic fatigue, lupus, etc.)

If any of the above needs to be detailed or if there is anything else to share, please do so:

Do you have any of the following today?

—skin —rash —cold/flu —open cuts —severe pain —contagious —injuries—
bruises

Do you have any allergies?

—medications —foods (nuts,etc.) —dust, pollen, fragrances, lotions, liquids,
skin/hair care products

If any of the above is checked, please give details:

Are you wearing?

—contact lenses —hearing aid —hairpiece —pacemaker

**Please indicate if you have any areas of your body in which you are feeling
discomfort/pain:**

What are your goals/expectations for this therapy session?

**The following sometimes occurs during massage. They are normal responses
to relaxation. Trust your body to express what it needs: need to move or
change position, sighing, yawning, change in breathing, stomach gurgling,
emotional feelings and/or movement of intestinal gas, energy shifts, falling
asleep and snoring.**