Health History:

Client Name: _____ Date of Birth: _____

Address: _____

E-Mail: _____ Telephone: _____

Who should I call in an emergency? _____What is their phone number? _____

What type of work do you do? _____

Did someone refer you to me? If yes, please write in their name: _____

Are you currently seeing a health care professional? ___Yes ___No
If yes, please list name(s) and reason/treatment: _____

Are you currently taking any medications? ___ Yes ___ No
If yes, please list name and reason for medication: _____

Are you currently pregnant? _____ Yes_____ No If yes, when is your due date? _____

Do you have any allergies or adverse reactions to environmental allergens, skin care products or foods?

Do you have (or are you wearing) any of the following **today**? ? (please circle all that apply)

- Skin Rash
- Severe Pain
- Cold/Flu
- Anything Contagious
- Open Cuts
- Injuries / Bruises
- Contact Lenses
- Dentures
- Hairpiece
- Hearing Aid

Please review the following list and check those conditions that have affected your health either recently or in the past.

- Anxiety and/or Panic Disorder
- Arthritis (where: _____)
- Auto-Immune Conditions:_____
- Back Pain/Problems. Herniated discs?_____
- Blood Clots
- Broken Bones (where/when:_____)
- Bruise Easily
- Cancer. Type:_____ In Remission?____
- Chemical Dependency
- Chronic Pain (where: _____)
- Constipation/Diarrhea
- Depression
- Diabetes
- Diverticulitis, Irritable Bowel, Crohn's Disease
- Headaches/ Migraines. How often? _____
- Heart Conditions: _____
- Hepatitis (A, B, C, other)
- High Blood Pressure. Regulated? __yes __no
- Insomnia
- Kidney Disease:
- Muscle Sprain / Strain (where/when: _____)
- Scoliosis
- Seizures
- Skin conditions
- Stroke (when: _____)
- Surgery (where/when: _____)
- TMJ disorder
- Whiplash (when: _____)

Open communication between the client and therapist about any issues that may affect the client's treatment and responsiveness to treatment is a vital aspect of effective massage therapy. It is important the client let the therapist know of any known issues, and also of any changes that may affect treatment. The services provided are not a replacement for medical or psychological care. Any information we provide is not prescriptive or diagnostic in nature, and is intended only to educate.

In order to provide the client with the best and most appropriate treatment, the therapist may discuss information pertinent to the client's condition(s) with associated LMTs, and/or with the health care providers the client has listed above. Please indicate that you understand and consent to the above by signing and dating below.

Client Signature: _____ **Date:** _____