

MESSAGE FOR YOUR BUSY LIFE

MassageTherapy - New Patient Confidential Health History Form

Personal Information:

Name: _____ DOB: _____
Phone (day): _____ Email: _____
Address: _____ Referred by: _____

The Following information will be used to plan a safe and effective massage session.

Have you received a professional massage? _____ Y / N
How often? _____

Do you have any difficulty laying on your front, back, or side? _____ Y / N
If Y explain: _____

Do you have allergies to oils, lotions, or ointments? _____ Y / N
If Y explain: _____

Do you stand / sit for long hours at a workstation, computer, or drive? _____ Y / N
If Y explain: _____

Do you perform repetitive movements in your work, sports, or hobby? _____ Y / N
If Y explain: _____

Do you experience stress in your work, family, or other aspects of your life?
If so how do you think it has affected your health? _____ Y / N

() muscle tension () anxiety () insomnia () irritability
If Y explain: _____

Is there any particular area of the body where you are experiencing tension, stiffness, pain, or other discomfort? _____ Y / N
If Y explain: _____

Signature: _____ Date: _____

Feel good. Live well.