HEALTH HISTORY FORM

Name_____ Date of Birth_____

Address_____ City_____ Zip Code_____

Primary Phone_____ Secondary Phone_____

E-mail Address_____

Emergency Contact Name_____ Phone_____

Food/Medication Allergies?_____

Referred by?_____

Occupation?_____ Exercise involvement?_____

Have you ever had a professional massage before? Y N
What kind of pressure do you prefer? Light Medium Firm
Any areas you **DO NOT** want massaged? Back gluteals legs feet arms hands neck scalp face

Are you currently under medical supervision?
If yes, Please list_____

List any current medications_____

Please list any recent or major accidents, surgeries, hospitalizations, injuries, and illnesses:
_____
_____

Please check any of the conditions that you have now or have experienced in the past & explain

□ Yes □ No Fungal infections_____
□ Yes □ No Psoriasis/Eczema_____
□ Yes □ No Skin allergies/sensitivities_____
□ Yes □ No Cosmetic Surgery_____
□ Yes □ No Bruise easily_____
□ Yes □ No Thrombophlebitis/Blood Clot_____
□ Yes □ No Varicose Veins_____
□ Yes □ No Heart disease/condition_____
□ Yes □ No Low/high blood pressure_____
□ Yes □ No Anemia_____
□ Yes □ No Diabetes_____
□ Yes □ No Clotting disorders_____
□ Yes □ No Edema_____
□ Yes □ No AIDS/HIV_____
□ Yes □ No Lupus_____
□ Yes □ No Current fever/flu/cold_____
□ Yes □ No Asthma/Emphysema_____

□ Yes □ No Joint Replacements_____
□ Yes □ No Arthritis/Osteo/Rheumatoid_____
□ Yes □ No TMJ Dysfunction_____
□ Yes □ No Strains/Sprains/tendonitis_____
□ Yes □ No Bursitis_____
□ Yes □ No Carpal tunnel syndrome_____
□ Yes □ No Broken/fractured bones_____
□ Yes □ No Fibromyalgia_____
□ Yes □ No Loss of motion or mobility_____
□ Yes □ No Sciatica Pain_____
□ Yes □ No Multiple Sclerosis_____
□ Yes □ No Numbness/tingling/reduced sensation_____
□ Yes □ No Current Pregnancy_____
□ Yes □ No Seizure disorder_____
□ Yes □ No Cancer_____
□ Yes □ No Wearing hearing Aid?_____
□ Yes □ No Wearing Dentures?_____

Signature_____ Date_____

A Touch of Haven Massage

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