HEALTH HISTORY

Name____ Date of Birth_____________________

Address____________________________________ City___________________ Zip Code___________

Cell Phone____Text message appointment reminders? YES / NO

E-mail Address____
Appointment reminders will be sent to this address 48 hours before scheduled time.

Emergency Contact Name_________________________________ Phone__________________________

Food/Medication Allergies?____

Occupation?___________________________________ Physically Active? Sport?_________________________

Have you ever had a professional massage before? Y N
Primary reason for massage? Explain any Chronic muscle discomforts and areas you want focused on.

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Any areas you **DO NOT** want massaged? feet hands neck scalp face glutes back legs arms
If under current medical supervision, please explain:

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Please list any **major** accidents, surgeries, hospitalizations, injuries, and illnesses:

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

- □ Yes □ No Current Pregnancy_______________________
- □ Yes □ No Current fever/flu/cold______________________
- □ Yes □ No Asthma/Emphysema______________________
- □ Yes □ No Psoriasis/Eczema_________________________
- □ Yes □ No Skin allergies/sensitivities__________________
- □ Yes □ No Fungal infections_________________________
- □ Yes □ No Bruise easily_____________________________
- □ Yes □ No Thrombophlebitis/Blood Clot________________
- □ Yes □ No Varicose Veins____________________________
- □ Yes □ No Heart disease/condition____________________
- □ Yes □ No Clotting disorders_________________________
- □ Yes □ No Low/high blood pressure___________________
- □ Yes □ No Diabetes__________________________________
- □ Yes □ No Cancer____
- □ Yes □ No Edema____
- □ Yes □ No Joint Replacements_________________________________
- □ Yes □ No Arthritis/Osteo/Rheumatoid___________________________
- □ Yes □ No Strains/Sprains/tendonitis___________________________
- □ Yes □ No Bursitis____
- □ Yes □ No Sciatica pain____
- □ Yes □ No Carpal tunnel syndrome______________________________
- □ Yes □ No Numbness/tingling/reduced sensation_________________
- □ Yes □ No Decreased range of motion or mobility_______________
- □ Yes □ No Fibromyalgia____
- □ Yes □ No Multiple Sclerosis____________________________________

Signature____ Date_____________________

W1014 County Rd FF
Sheboygan, WI 53083

PHONE: 920-565-0120
EMAIL:
atouchofhaven@massagetherapy.com
WEB SITE: www.atouchofhaven.com