Medical History Form

Relax Already Therapeutic Massage

Name _____ **Date** _____

Address _____ **City/Town** _____

State _____ **Zip Code** _____ **Phone (H)** _____ **(C)** _____

Date of Birth _____ **Occupation** _____

Email _____

Primary Physician _____ **Date of Last Physical** _____

Medications (Use other side if needed) _____

Referred By _____

What is your previous massage experience? _____

What is your reason for choosing massage and what results do you expect from this treatment?

What are your exercise habits?

Circle any of the following conditions that you have and describe on the other side:

Allergies	Depression	Blood Clots
Arthritis	Diabetes	Pins/Pacemaker/Rods
Anemia	Digestion Problems	Pregnancy
Anxiety	Dizziness/Fainting	Psychiatric
Asthma	Fatigue	Recent Surgery (w/in 6 mos.)
Athlete's Foot	Fibromyalgia	Respiratory
Bleeding/Bruising	Headaches	Seizures/Epilepsy
Blood Pressure Problems	Hepatitis	Sinus Problems
Bursitis	Hernia	Skin Conditions _____
Cancer_____	Joint Problems	Smoker
Cardiac Issues	Kidney/Urinary	Stress
Circulation Problems	Liver/Gall Bladder	Ulcers
Cold Sweats	Muscle Strain/Sprain	Varicose Veins
Contact Lenses	Osteoporosis	Vertebral/Disc Problems

Other (include any other conditions, syndromes, recent accidents and anything else pertinent to your health status):

Where do you hold your tension and pain?

Signature _____ **Date** _____

Parent or Guardian's Signature _____ **Date** _____