

THE MASSAGE ROOM

Client Health History Information

 Please check here if you would prefer not to have mailings to your home

NAME: _____

ADDRESS: _____ CITY: _____ STATE: _____ ZIP: _____

PHONES: HOME# _____ CELL# _____ WORK# _____

E-MAIL ADDRESS: _____

DATE OF BIRTH: _____ AGE: _____ MARITAL STATUS _____

OCCUPATION: _____ REFERRED BY: _____

EMERGENCY CONTACT: NAME: _____ PHONE#: _____

HAVE YOU EVER HAD A MASSAGE? Y ___ N ___ TYPE: _____ WHEN: _____

ARE YOU PREGNANT? Y ___ N ___ ARE YOU TAKING MEDICATIONS? Y ___ N ___

NAMES OF MEDICATIONS: _____

HAVE YOU CONSUMED ANY ALCOHOLIC BEVERAGES IN THE LAST 24 HOURS? Y ___ N ___

CURRENT HEALTH INFORMATION

LOCATION OF CURRENT PAIN: _____ RANGE 1 TO 10 (10 BEING THE WORST) _____

OTHER AREAS: NECK _____ SHOULDERS _____ ARMS _____ LOWER BACK _____

UPPER BACK _____ LEGS _____ FEET _____

CHECK ALL PHYSICAL CONDITIONS THAT APPLY

HABITS: TOBACCO _____ ALCOHOL _____ DRUGS _____ CAFFEINE _____

GENERAL: HEADACHES _____ PAIN _____ SLEEP DISTURBANCES _____ FATIGUE _____

INFECTIONS _____ SINUS _____ OTHER _____

SKIN CONDITIONS: RASHES _____ ATHLETE'S FOOT _____ OTHER _____

ALLERGIES: PERFUMES _____ DETERGENTS _____ LATEX _____ OTHER _____

RESPIRATORY/CARDIOVASCULAR

HEART DISEASE _____ BLOOD CLOTS _____ STROKE _____ HIGH/LOW BLOOD PRESSURE _____

LYMPHADEMA _____ SWOLLEN ANKLES _____ IRREGULAR HEARTBEAT _____ POOR CIRCULATION _____

VARICOSE VEINS _____ CHEST PAIN/SHORTNESS OF BREATH _____ ASTHMA _____