



Massage Medical History Form

Name _____ DOB _____ Date _____

Street Address _____

City, State, Zip Code _____

Phone Number (_____) _____ - _____ Alternate Number (_____) _____ - _____

Occupation _____

Gender **Female** **Male**

Emergency Contact (Relation) _____

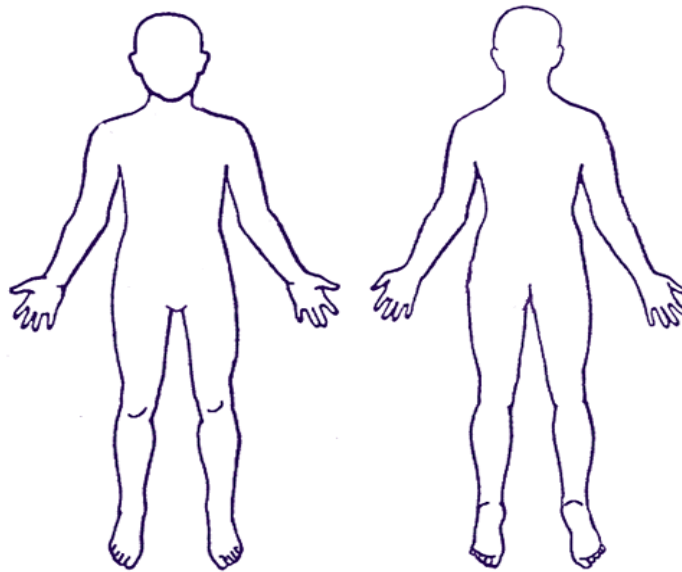
Emergency Contact Phone Number (_____) _____ - _____

- 1) Have you ever received a massage before? **Yes** **No**
- 2) On a pain scale of 1 to 10, 1 being low and 10 being high, please rate your **stress level** _____
- 3) On a pain scale of 1 to 10, 1 being low and 10 being high, please rate your **energy level** _____
- 4) On a pain scale of 1 to 10, 1 being low and 10 being high, please rate you **pain level** _____
- 5) Are you are you currently experiencing any stress or pain on you body? **Yes** **No**
- 6) List areas of pain/stress, and if the pain/stress is constant or periodic:

7) Do you have any allergies? **Yes** **No** If yes, please list allergies: _____

8) Do you have any recent or past injuries or surgeries that give you reoccurring discomfort?
Yes **No** If yes, please describe: _____

9) On diagram, circle area(s) of pain:



Front-Anterior

Back-Posterior

10) Please circle any conditions that apply to you, past or present:

- Anxiety Back Problems/Pain Blood Clots Bruise Easily Bunions Cancer
- Contact Lenses Depression Diabetes Digestive/Bowel Problems Epilepsy Fatigue Fibromyalgia
- Flat Feet Fractured/Broken Bone(s) Fungal Infection Headaches
- Heart Disease/Problems High Blood Pressure HIV Hyper/hypo Thyroid Implanted Device
- Insomnia Jaw Pain Joint Stiffness or Swelling Kyphosis Lordosis Low Blood Pressure
- Motor Vehicle Accident Multiple Sclerosis Muscular Problems Neck Problems
- Numbness/Tingling Osteoarthritis Paralysis Parkinson's PMS Pregnant
- Pressure Sensitivity Prosthetic Respiratory Problems Scoliosis Seizure Disorders
- Skin Condition Stroke Tendonitis Temperature Sensitivity Transdermal Patch
- Ulcers Urinary Problems Varicose Veins Viral Infection

11) Comments concerning any of the above, or any conditions not mentioned above: _____

12) Do you smoke? **Yes** **No**

13) Do you consume alcohol? **Yes** **No**

14) Do consume caffeine or sugar daily? **Yes** **No**

15) Massage can include work on the face, chest, abdomen, hips, and gluteus muscles. Do you have any preference about these areas being worked on? **Yes** **No** If yes, please list areas to avoid:



I, _____, agree that the information provided on this medical form is true to the best of my knowledge. I freely give permission to receive medical massage therapy. I understand the practitioner is a licensed massage therapist, not a medical doctor or healthcare provider. I understand that massage therapy should not be construed as a substitute for medical examination, diagnosis, or treatment; and that I should see a medical physician or other healthcare specialist to address concerns that are outside the scope of the massage therapists' practice. I understand the massage therapist will be following and practicing state regulation guidelines for proper draping throughout the duration of the massage; and that I have the option to request additional draping for my own comfort and security as I see fit. I agree to inform the massage therapist of any pain experienced during the initial and subsequent sessions. Massage is the manipulation of the soft tissues, including the skin, the muscles, and the structures contained therein, for a therapeutic effect that promotes increased circulation, detoxification, reducing physical and emotional stress, and increasing the body's general well-being. I understand the intent is to do no harm, and I will not hold the massage therapist liable for any information which I have not previously provided in this medical history.

Client Signature _____ Date _____

LMT Signature _____ Date _____

Disclaimer- Actions or behavior deemed as inappropriate as observed by the Licensed Massage Therapist could result in termination of the massage session, with the client being responsible for full payment of the session. Severe conduit could result in removal from the Face and Eye Aesthetic Center practice.