



Massage Therapy Health History

Occupation: _____ Recreational Activities: _____

What is your communication preference during the massage? *(please circle one)*

I love to chat Please don't talk, I'd like to fully relax I'd like a little of both

What type of massage are you looking for? Deep Tissue Lymph Drainage Craniosacral Other

If Other, please describe: _____

Health History

Have you ever experienced any of the following? Please use "C" for Current, "P" for past, or "S" for Sometimes

- | | | | |
|--|---|---|--|
| <input type="checkbox"/> AIDS/HIV | <input type="checkbox"/> Colitis | <input type="checkbox"/> Headaches | <input type="checkbox"/> Ringworm |
| <input type="checkbox"/> Allergies | <input type="checkbox"/> Concussion / TBI | <input type="checkbox"/> Heart Attack /Conditions | <input type="checkbox"/> Sciatica |
| <input type="checkbox"/> Anemia | <input type="checkbox"/> Constipation | <input type="checkbox"/> Hemophilia | <input type="checkbox"/> Skin Allergies |
| <input type="checkbox"/> Arthritis | <input type="checkbox"/> Covid | <input type="checkbox"/> Herpes | <input type="checkbox"/> Sprains/ Strains |
| <input type="checkbox"/> Athletes Foot | <input type="checkbox"/> Diabetes | <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Stiff Joints |
| <input type="checkbox"/> Auto Immune Disorders | <input type="checkbox"/> Diarrhea | <input type="checkbox"/> Insomnia | <input type="checkbox"/> Stroke |
| <input type="checkbox"/> Back Pain | <input type="checkbox"/> Digestive Problems | <input type="checkbox"/> Low Blood Pressure | <input type="checkbox"/> Swollen Feet/Legs - Edema |
| <input type="checkbox"/> Blood Clots | <input type="checkbox"/> Disc Problems | <input type="checkbox"/> Migraines | <input type="checkbox"/> Tendonitis |
| <input type="checkbox"/> Bone Fractures | <input type="checkbox"/> Diverticulitis | <input type="checkbox"/> Muscle Spasms | <input type="checkbox"/> Tumors |
| <input type="checkbox"/> Bursitis | <input type="checkbox"/> Eczema | <input type="checkbox"/> Numbness | <input type="checkbox"/> Varicose Veins |
| <input type="checkbox"/> Cancer | <input type="checkbox"/> Epilepsy/Seizures | <input type="checkbox"/> Phlebitis | <input type="checkbox"/> Vertigo/ Dizziness |
| <input type="checkbox"/> Chronic Fatigue | <input type="checkbox"/> Excess Stress | <input type="checkbox"/> Psoriasis | <input type="checkbox"/> Whiplash |
| <input type="checkbox"/> Circulatory Problems | <input type="checkbox"/> Fibromyalgia | <input type="checkbox"/> Rashes | |
| <input type="checkbox"/> Other: _____ | | | |

For Women Only:

- | | | | |
|---|-----------------------|---|-------------------------------------|
| <input type="checkbox"/> Pregnant | How many months _____ | <input type="checkbox"/> Menstrual Cramps | <input type="checkbox"/> Amenorrhea |
| <input type="checkbox"/> Trying to get pregnant | How many months _____ | <input type="checkbox"/> Excessive Bleeding | <input type="checkbox"/> PMS |

Accidents, Motor Vehicle Accidents: *(Please briefly describe and provide a date)*

Less than 5 years ago: _____

More than 5 years ago: _____

Surgeries, Replacements, Injuries: *(Please briefly describe and provide a date)*

Flip Over

Are you currently under medical supervision or receiving medical treatment? Yes No

If yes, please explain: _____

Patient Present Complaints

What is your chief complaint: _____

When did your symptoms first appear? _____

How did they appear? _____

Is this condition getting progressively worse? Yes No Not Sure/No change

Average Pain Intensity

Pain Level Right Now	0	1	2	3	4	5	6	7	8	9	10
Pain level the Past Week	0	1	2	3	4	5	6	7	8	9	10
Pain level at the Worst	0	1	2	3	4	5	6	7	8	9	10
Pain level at the best	0	1	2	3	4	5	6	7	8	9	10

What is the frequency of your symptoms?

Constantly Frequently Occasionally Intermittent

How much have your symptoms interfered with your usual daily activities?

Extremely Quite a Bit Moderately A Little Not at all

Does it interfere with your:

Work Sleep Daily Routine Recreation

Activities and/or movements that are painful to perform:

Sitting Standing Walking Bending

Lying Down Other: _____

What time is the pain the worst?

Morning Afternoon Evening Constant

What is the quality of the pain? (Throbbing, sharp, shooting, tingling, etc.)

What makes it worse? _____

What makes it better? _____

Please describe the pain in the areas marked in the picture.

Mark the picture below where you have pain.

