Massage Health History Form

The information requested below will assist us in providing you with safe treatments. Please ask your therapist if you have any questions about the information being requested. All information provided below will be kept as confidential unless allowed or required by law. Your written permission will be required to release any information.

Client Information

Name ______________________________ Email ______________________________

Phone (cell/day) ______________________________ DOB ______________ Age: __________

Address ______________________________ City/State/Zip ______________________________

Emergency Contact Name ______________________ Phone ______________ Relationship ______________

Occupation ______________________________ Referred by: ______________________________

Health Information

Condition	yes	no	Condition	yes	no
Anxiety / stress	☐ yes	☐ no	Muscle weakness	☐ yes	☐ no
Bleeding disorder	☐ yes	☐ no	Neuropathy	☐ yes	☐ no
Blood clot	☐ yes	☐ no	Osteoarthritis	☐ yes	☐ no
Bruise easily	☐ yes	☐ no	Osteoporosis	☐ yes	☐ no
Bursitis	☐ yes	☐ no	Phlebitis/varicose veins	☐ yes	☐ no
Cancer / tumor	☐ yes	☐ no	Rheumatoid arthritis	☐ yes	☐ no
Depression	☐ yes	☐ no	Sciatica	☐ yes	☐ no
Diabetes	☐ yes	☐ no	Seizures	☐ yes	☐ no
Fibromyalgia	☐ yes	☐ no	Stroke / CVA	☐ yes	☐ no
Hearing loss	☐ yes	☐ no	Tuberculosis	☐ yes	☐ no
High blood pressure	☐ yes	☐ no	Tendinitis	☐ yes	☐ no
Low blood pressure	☐ yes	☐ no	TMJ disorder	☐ yes	☐ no
Kidney disease	☐ yes	☐ no	Vertigo / dizziness	☐ yes	☐ no
Multiple sclerosis	☐ yes	☐ no	Vision impairment	☐ yes	☐ no

Notes: ______________________________

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Any skin conditions? ☐ yes ☐ no ______________________________

Neurological conditions? ☐ yes ☐ no ______________________________

Heart condition? ☐ yes ☐ no ______________________________

Autoimmune disorder? ☐ yes ☐ no ______________________________

Digestive problem? ☐ yes ☐ no ______________________________

Endocrine disorder? ☐ yes ☐ no ______________________________

Respiratory disorder? ☐ yes ☐ no ______________________________

Areas of swelling? ☐ yes ☐ no ______________________________

Frequent headaches? ☐ yes ☐ no ______________________________

Areas of numbness or decreased sensation? ______________________________

Areas of broken skin? (e.g. rash, wounds) ☐ yes ☐ no If yes, where? ______________________________

Any current infectious or contagious conditions? (e.g. HIV, TB, fungal infections, shingles, warts, etc.) ☐ yes ☐ no

If yes, please list: ______________________________

Are you taking any medications? If yes, please list: ______________________________

Any allergies or hypersensitivities? (oils, lotions, nuts, fruits, skin, etc.) ☐ yes ☐ no ____________________________

Are you pregnant? ☐ yes ☐ no If yes, how many months: ___________ Due date: _________________

History of joint replacement surgery? ☐ yes ☐ no Which joint(s) ? ____

Any implants? (e.g. pacemaker, insulin pump, metal) ☐ yes ☐ no What, where? ________________________________

Are you you currently under medical supervision or receiving other medical interventions?

If yes, please describe: ____

Recent injuries or medical procedures in the past 2 years? ☐ yes ☐ no Please describe: ______________________

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Please describe any other injuries or health conditions: ____

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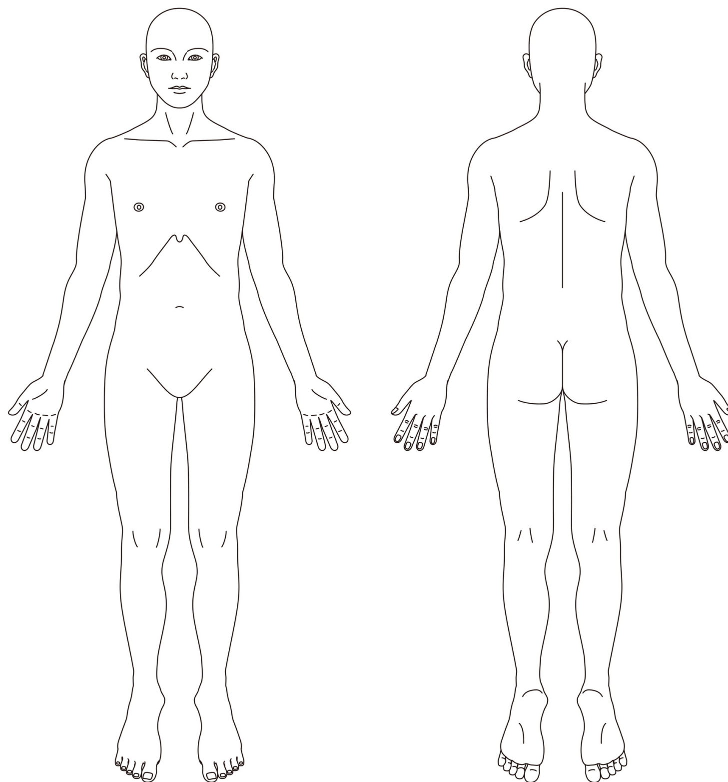
Have you had professional massage before? ☐ yes ☐ no How recently? ____

Reason for seeking massage: ☐ Relaxation ☐ Specific problem ____

How much pressure do you prefer? ☐ Light ☐ Medium ☐ Firm

Please indicate any areas of pain or discomfort



By signing below, I acknowledge that I am aware of the benefits and risks of massage therapy and that I have completed this form accurately and truthfully to the best of my knowledge. I also agree to inform my massage therapist of any health or medical changes.

Client Signature ______________________________________ Date _____________

Therapist Signature ___________________________________ Date _____________