Health & Harmony Massage Therapy

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Date_____

Print Form

Health Information

A. Client Information

Name_____

Address_____

City_____State____Zip_____

Phone: Home_____

Work_____Cell_____

Email address_____

Date of Birth____/____/_____

Employer_____

Occupation_____

Emergency Contact_____

Phone: _____

Primary Health Care Provider (Dr.)

Name_____

Address_____

City_____State____Zip_____

Phone_____Fax_____

I give my massage therapist permission to consult with my primary health care provider regarding my health and treatment as needed.

Comments_____

Initials_____Date_____

B. Current Health Information

List current concerns. Check all that apply.

Primary_____
☐ mild ☐ moderate ☐ disabling
☐ constant ☐ intermittent
☐ symptoms ↑ w/ activity ☐ ↓ w/ activity
☐ getting worse ☐ getting better ☐ no change
Treatment received_____

Secondary_____
☐ mild ☐ moderate ☐ disabling
☐ constant ☐ intermittent
☐ symptoms ↑ w/ activity ☐ ↓ w/ activity
☐ getting worse ☐ getting better ☐ no change
Treatment received_____

Other_____
☐ mild ☐ moderate ☐ disabling
☐ constant ☐ intermittent
☐ symptoms ↑ w/ activity ☐ ↓ w/ activity
☐ getting worse ☐ getting better ☐ no change
Treatment received_____

Have you ever received a professional massage?
☐ Yes ☐ No How recently?_____
How did you hear about Health and Harmony?
_____

List all conditions currently being monitored by a health care provider_____

_____

_____

List all medications you took today (include pain relievers and herbal remedies) _____

_____

_____

List all other medications taken in the past 3 months_____

_____

List Typical Daily Activities

Work_____

_____

Home/Family_____

_____

Social/Recreational_____

_____

Circle the activities affected by your condition.
☐ all of the above
Check other activities affected:
☐ sleep ☐ washing ☐ dressing ☐ fitness
How do you reduce stress? _____

_____

Pain?_____

What are your goals in receiving massage?

_____

_____

C. Health History

List and explain any surgeries, accidents or major illnesses, including dates and treatment received.

_____

_____

_____

_____

Check All Current and Previous Conditions. Please explain. **Health Information** page 2

General

current past
- ☐ ☐ headaches
- ☐ ☐ pain
- ☐ ☐ sleep disturbances
- ☐ ☐ fatigue
- ☐ ☐ infections
- ☐ ☐ fever
- ☐ ☐ sinus
- ☐ ☐ other_____

comments_____

_____

_____

_____

Skin Conditions

current past
- ☐ ☐ rashes
- ☐ ☐ athlete's foot
- ☐ ☐ warts
- ☐ ☐ other_____

comments_____

_____

_____

_____

Allergies

current past
- ☐ ☐ scents
- ☐ ☐ detergents
- ☐ ☐ oils, lotions
- ☐ ☐ other

comments_____

_____

_____

_____

Muscles and Joints

current past
- ☐ ☐ rheumatoid arthritis
- ☐ ☐ osteoarthritis
- ☐ ☐ osteoporosis
- ☐ ☐ scoliosis
- ☐ ☐ broken bones
- ☐ ☐ spinal problems
- ☐ ☐ disk problems
- ☐ ☐ lupus
- ☐ ☐ TMJ, jaw pain
- ☐ ☐ spasms, cramps
- ☐ ☐ sprains, strains
- ☐ ☐ tendonitis, bursitis
- ☐ ☐ stiff/painful joints
- ☐ ☐ weak or sore muscles
- ☐ ☐ fibromyalgia
- ☐ ☐ neck, shoulder, arm pain
- ☐ ☐ low back, hip, leg pain
- ☐ ☐ other _____

comments_____

_____

_____

_____

_____

Nervous System

current past
- ☐ ☐ head injuries, concussion
- ☐ ☐ dizziness, ringing in ears
- ☐ ☐ loss of memory, confusion
- ☐ ☐ numbness, tingling
- ☐ ☐ sciatica, shooting pain
- ☐ ☐ chronic pain
- ☐ ☐ depression
- ☐ ☐ other_____

comments_____

_____

_____

_____

Respiratory, Cardiovascular

current past
- ☐ ☐ heart disease
- ☐ ☐ blood clots
- ☐ ☐ stroke
- ☐ ☐ lymphadema
- ☐ ☐ high/low blood pressure
- ☐ ☐ irregular heart beat
- ☐ ☐ poor circulation
- ☐ ☐ swollen ankles
- ☐ ☐ varicose veins
- ☐ ☐ chest pain, shortness of breath
- ☐ ☐ asthma
- ☐ ☐ other_____

comments_____

_____

_____

_____

Endocrine System

current past
- ☐ ☐ thyroid dysfunction
- ☐ ☐ diabetes

comments_____

_____

_____

_____

Digestive/Elimination System

current past
- ☐ ☐ bowel dysfunction
- ☐ ☐ gas, bloating
- ☐ ☐ bladder/kidney dysfunction
- ☐ ☐ abdominal pain
- ☐ ☐ other_____

comments_____

_____

_____

_____

Reproductive System

current past
- ☐ ☐ pregnancy
- ☐ ☐ painful, emotional menses (PMS)
- ☐ ☐ fibrotic cysts
- ☐ ☐ other_____

comments_____

_____

_____

_____

Cancer/Tumors

current past
- ☐ ☐ benign
- ☐ ☐ malignant
- ☐ ☐ other_____

comments_____

_____

_____

_____

Habits

current past
- ☐ ☐ tobacco
- ☐ ☐ alcohol
- ☐ ☐ drugs
- ☐ ☐ coffee, soda

comments_____

_____

_____

_____

Consent for Care

I have completed this form to the best of my knowledge. I understand massage services are to be a health aid and in no way to take the place of a doctor's care when indicated. Information exchanged during any massage session is educational in nature, helping me become more familiar and conscious of my own health status. I will communicate any pain or discomfort experienced during massage so that my therapist can adjust the pressure/strokes accordingly. I agree to keep my therapist informed of any changes in my medical profile.

Signature_____ Date_____

Signature of parent/guardian_____ Date _____
(If client is a minor)