# Medical History Form

The following information will be used to help your therapist plan a safe and effective massage session. Please answer the questions to the best of your knowledge.

Have you had a professional massage before? ___Yes ___ No If yes, how often?

_____

Are you wearing  contact lenses,  dentures, or hearing aids?

_____

Are you pregnant? If yes, how far along are you?

_____

Is there a specific area of the body where you are experiencing tension, stiffness, pain or discomfort? ___Yes ___ No If yes, please identify

_____

## Do you currently or have you ever had any of the following Conditions: (please circle)

Heart Condition
Blood Clots
High Blood Pressure
Circulatory Disorder
Varicose Veins
Diabetes
Arthritis
Epilepsy/Seizures
Osteoporosis
Fibromyalgia
Carpal Tunnel Syndrome
Asthma
Scoliosis
Cancer

Allergies/Sensitivity
Recent Accident or Injury
Surgeries (Explain Below)
Sprains/Strains
Joint Disorder
Back/neck problems
Tension/Soreness
Swelling
Headaches/Migraines
Bruise Easily
Numbness/Stabbing Pains
Sensitive to Touch/Pressure
Anxiety/Stress

Other Medical Conditions_____

_____

_____

*Continue on Back*

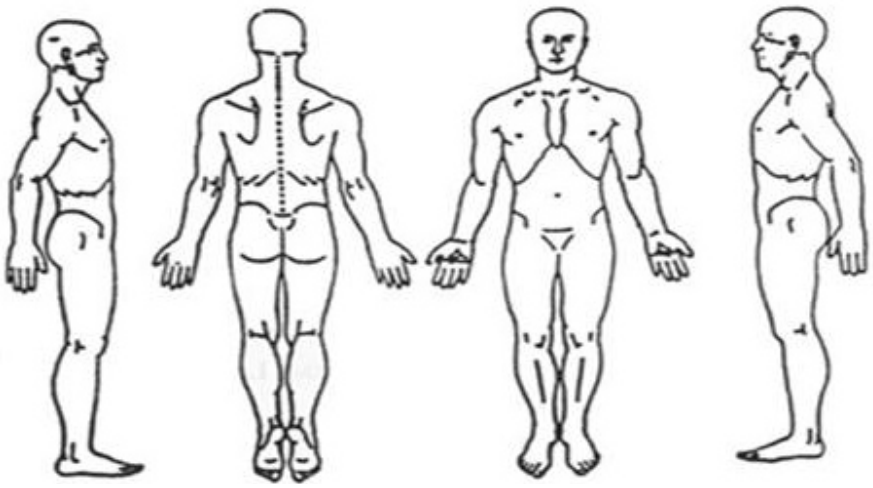
Are you currently taking any medication? ___ Yes ___ No If yes, please list _

_____

_____

_____

Circle any specific areas you are feeling discomfort:



_____

I, _____ understand that the massage I receive is provided for the basic purpose of relaxation and relief of muscular tension. If I experience any pain or discomfort during my session, I will immediately inform the therapist so that the pressure and/or strokes may be adjusted to my level of comfort. I further understand that massage should not be construed as a substitute for medical examination, diagnosis, or treatment and that I should see a physician other qualified medical specialist for any mental or physical ailment that I am aware of. I understand that massage therapists are not qualified to perform adjustments, diagnose, prescribe, or treat any physical or mental illness, and that nothing said in the course of the session given should be construed as such. Because massage should not be performed under certain medical conditions, I affirm that I have stated all my known medical conditions, and answered all questions honestly. I agree to keep the therapist updated as to any changes in my medical profile and understand that there shall be no liability on the therapist's part should I fail to do so.

Signature of Client_____ Date_____

Signature of Massage Therapist _____ Date_____