



## Massage Therapy Health History Form

Appointment Date: \_\_\_\_\_

<b>Client Name:</b>	
<b>Client Address:</b>	
<b>Client Phone:</b>	
<b>Emergency Contact Name:</b>	
<b>Emergency Contact Phone:</b>	
<b>Client Date of Birth:</b>	
<b>Client Age:</b>	
<b>Physician's Name:</b>	
<b>Physician's Phone:</b>	

*What type of pressure do you prefer?* Light                  Medium                  Firm

*Are you sensitive to touch. if so where?*

*What are your goals for receiving massage therapy?* Pain Relief                  Relaxation                  Improved Athletic Performance

*If receiving massage therapy to address pain relief please list your symptoms/issues:*

*Do these symptoms interfere with your activities of daily living? CIRCLE:*    Exercise    Sleep    Work

*Are you pregnant?* Yes    No

*Do you wear contact lenses?* Yes    No

*Do you wear dentures?* Yes    No

*Are you currently taking blood thinners, pain medications or insulin, if so, please indicate*

*Do you have any allergies? If so, please list.* \_\_\_\_\_

*Do you have cancer or are you in remission? Please indicate:* \_\_\_\_\_

*Did you have a lymphectomy?* \_\_\_\_\_

*Other medical conditions, or are you taking any medications I should know about?* \_\_\_\_\_

*Please circle if you have experienced the following:*

Stress	Diabetes	Bruise Easily	Frequent Headaches
Arthritis	High Blood Pressure	Epilepsy	Suffer from Back Pain
Varicose Veins	Osteoporosis	Joint Swelling	Digestive Conditions
Vertigo	Dizziness/Ringing in ears	Fibromyalgia	Scoliosis

I have read and understand the possible contraindications to massage therapy. I further understand that massage should not be construed as a substitute for medical care. I agree to update the massage therapist in written correspondence as to any changes in my medical profile and understand that there shall be no liability on the therapist's part should I forget to do so.

I understand that the practice of Massage Therapy is a separate and distinct business entity than therapy from Hollenbach Family Chiropractic provided by Dr. James Hollenbach at 250 Main Street, Madison, NJ 07940

Patient's Signature

Please Print and Sign Patient Name: \_\_\_\_\_