



Massage Therapy Health History Form

Appointment Date: _____

Client Name:	
Client Address:	
Client Phone:	
Client Email:	
Emergency Contact Name:	
Emergency Contact Phone	
Client Date of Birth:	
Client Age:	
Physician's Name:	
Physician's Phone:	

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 lumpectomy? _____

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	Fibomyalgia	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: _____