
# MASSAGE / PERSONAL HISTORY

**Today's Date** _____

**Patient**_____**Address**_____

**City**_____ **State**_____ **Zip**_____

**Sex**_____ **Age**_____ **Birthdate**_____ **Martial status**_____ **SS#**_____

**Occupation**_____**Employer**_____**Employer phone**_____

**Spouse's name**_____ **Work Phone**_____ **Cell**_____

**Home #**_____**Work #**_____**Ext**_____**Cell #**_____

**IN CASE OF EMERGENCY, CONTACT:**

**Name**_____ **Relationship**_____**Phone**_____**Cell**_____

**If you answer "yes" to any of the following questions, please explain briefly:**

**Yes ___ No ___ Have you experienced a professional massage before?**

**Yes ___ No ___ Are you wearing contact lenses?**

**Yes ___ No ___ Are you diabetic? Using insulin _____ Using medication _____ Other _____**

**Yes ___ No ___ Do you have any heart or blood circulation problems?**

**Yes ___ No ___ Are you pregnant? If so, how far along are you? _____**

**Yes ___ No ___ Do you have back pain? Upper _____ Middle _____ Lower_____**

**Yes ___ No ___ Are you being treated for cancer?**

**Yes ___ No ___ Are you being treated for epilepsy or seizures?**

**Yes ___ No ___ Do you have numbness or stabbing pains anywhere?**

**Yes ___ No ___ Do you have any other medical or skin condition(s) of which your therapist should be aware?**

**Yes ___ No ___ Do you have any tension or soreness in a specific area? If so, where? _____**

**Yes ___ No ___ Are you very sensitive to touch/pressure in any area? If so, where? _____**

**Yes ___ No ___ Do you have varicose veins?**

**List medication/nutrients now taking and why:**

**1.**_____

**2.**_____

**3.**_____

**4.**_____

**List any injuries/operation/pertinent history w/dates:**

**1.**_____

**2.**_____

**3.**_____

**4.**_____

_____ _____

**Signature** **Date**

_____ _____ _____

**Signature of Parent or Guardian** **Relationship** **Date**