

# Personal Health History

Please print all information clearly

ALL INFORMATION IS STRICTLY  
PERSONAL AND CONFIDENTIAL

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14 S Main Street Greenville, SC 29601

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

Name: \_\_\_\_\_ Age: \_\_\_\_\_ DOB: \_\_\_\_\_

Phone: (H) \_\_\_\_\_ (C) \_\_\_\_\_ (W) \_\_\_\_\_ Email: \_\_\_\_\_

Address: \_\_\_\_\_ Apt # \_\_\_\_\_ City \_\_\_\_\_ State: \_\_\_\_\_ Zip code: \_\_\_\_\_

Current Height: \_\_\_\_\_ Current Weight: \_\_\_\_\_ Gender: Male \_\_\_\_\_ Female \_\_\_\_\_

Occupation: \_\_\_\_\_

Referred here by: \_\_\_\_\_

Employer: \_\_\_\_\_

Have you ever had a professional massage? YES  NO  If yes, date of last massage: \_\_\_\_\_

What are your expectations from this session? (relaxation, pain/stress relief, etc.) \_\_\_\_\_

Name of primary physician: \_\_\_\_\_

Permission to consult with primary physician: YES  NO  If yes, please initial here: \_\_\_\_\_

In case of emergency, contact: \_\_\_\_\_ Relationship: \_\_\_\_\_ Phone Number: \_\_\_\_\_

Are you currently taking any medications? YES  NO

If yes, please list medication and reason for prescription, (include aspirin/ibuprofen, vitamins, herbs, etc):

Medication(s)	Reason
_____	_____
_____	_____
_____	_____
_____	_____

Do you wear: Contact Lenses  Dentures  Hearing Aid  Prosthesis

Are you currently under the guidance of a coach or personal/athletic trainer? YES  NO

What do you do to reduce your stress? \_\_\_\_\_

**Check all that apply:**

- |  |   |  |  |
|--|---|--|--|
| <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Depression     | <input type="checkbox"/> Scoliosis           | <input type="checkbox"/> Decreased ROM     |
| <input type="checkbox"/> Low Blood Pressure  | <input type="checkbox"/> HIV            | <input type="checkbox"/> Neck Pain           | <input type="checkbox"/> Herniated Discs   |
| <input type="checkbox"/> Heart Condition     | <input type="checkbox"/> Sinus Problems | <input type="checkbox"/> Jaw Pain/ TMJ       | <input type="checkbox"/> Arthritis         |
| <input type="checkbox"/> Nervous Condition   | <input type="checkbox"/> Recent Fever   | <input type="checkbox"/> Broken Bones        | <input type="checkbox"/> Inflammation      |
| <input type="checkbox"/> Diabetes            | <input type="checkbox"/> Skin disorders | <input type="checkbox"/> Vertebral Surgeries | <input type="checkbox"/> Tendonitis        |
| <input type="checkbox"/> Epilepsy            | <input type="checkbox"/> Allergies      | <input type="checkbox"/> Stiff Neck          | <input type="checkbox"/> Shoulder/Arm Pain |
| <input type="checkbox"/> Cancer              | <input type="checkbox"/> Hypoglycemia   | <input type="checkbox"/> Hernia/Rupture      |  |
| <input type="checkbox"/> Asthma              | <input type="checkbox"/> Emphysema      | <input type="checkbox"/> Whip Lash           |  |
| <input type="checkbox"/> Varicose Veins      | <input type="checkbox"/> PMS            | <input type="checkbox"/> Serious Accident    |  |
| <input type="checkbox"/> Rashes              | <input type="checkbox"/> Blood Clots    | <input type="checkbox"/> Low Back/Hip Pain   |  |
| <input type="checkbox"/> Headaches           | <input type="checkbox"/> Pregnancy      | <input type="checkbox"/> Bursitis            |  |
| <input type="checkbox"/> Migraines           | <input type="checkbox"/> Insomnia       | <input type="checkbox"/> Fractures           |  |

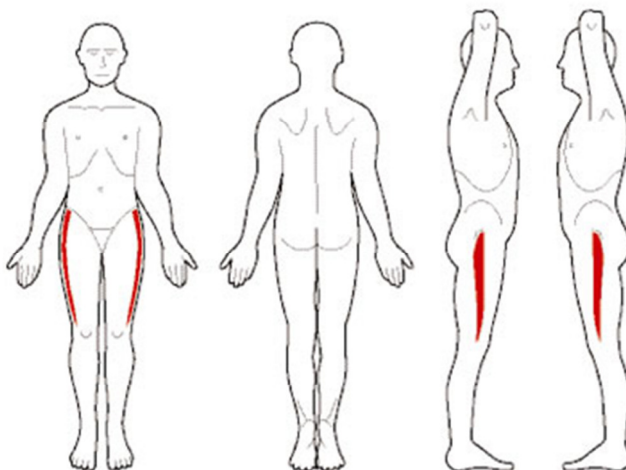
List any surgeries: \_\_\_\_\_

List any accidents: \_\_\_\_\_

Mark the areas of the body that you give permission to receive massage:

- Head     Face     Neck     Arms     Chest     Abdomen  
 Legs     Buttocks/Gluteus     Back

Using the diagrams, please indicate any areas of pain or discomfort.



It is my choice to receive massage therapy and I acknowledge that all therapy received by me is to be of a therapeutic nature for the relaxation and well-being of my body and mind. I agree to communicate with my therapist if I feel that my well-being is being compromised. I understand that massage therapists do not diagnose illness, disease, or any physical or mental disorders; nor do they do any spinal manipulations or prescribe any medical treatments or pharmaceuticals. I understand that massage is not a substitute for medical examination or diagnosis, and that it is recommended that I see my primary physician for those services. I have stated all medical conditions that I am aware of and will advise my therapist of any changes in my health status. I also agree to give at least a 24 hour cancellation notice if I cannot meet my scheduled appointment so that another client may be scheduled in that time slot. Otherwise, a \$25 cancellation fee will be charged.

Thank you for your appointment today! Relax and enjoy your massage!

Signature: \_\_\_\_\_

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