Nourish

Massage Bodywork & Skin Therapies

Massage Therapy Health History

Contact Information:

Name: _____ Date: _____

Email: _____ Phone: _____

Massage History/Treatment Information:

Have you ever received a professional massage before? ☐ yes ☐ no

What results would you like from your massage sessions?

_____

_____

Please prioritize the areas of your body that you would prefer to be massaged.

_____

Please check the areas of your body that you give permission to receive massage:

☐ Scalp ☐ Face ☐ Décolleté/Chest ☐ Arms ☐ Back

☐ Abdomen ☐ Legs ☐ Feet ☐ Glutes ☐ Neck

Are you currently seeing a medical practitioner? Please explain if yes. ☐ yes ☐ no

_____

List exercise & stress reduction activities including frequency.

_____

List all medications/supplements that you are currently on including Tylenol, aspirin, ibuprofen, etc.

_____

_____

Please list any surgeries/accidents including year and treatment(s) received.

_____

_____

Health History

Skin

____ allergies _____
____ rashes _____
____ athletes foot _____
____ warts _____
____ excema/psoriasis _____

Digestive

____ constipation _____
____ gas/bloating _____
____ diverticulitis _____
____ irritable bowel syndrome _____

Nervous System

____ herpes/shingles _____
____ numbness/tingling _____
____ chronic pain _____
____ fatigue _____
____ sleep disorders _____

Other

____ cancer _____
____ diabetes _____
____ eating disorders _____
____ depression _____
____ drug/alcohol addiction _____
____ nicotine/caffeine addiction _____
____ sleep disorders _____

Musculo-skeletal

____ bone or joint disease _____
____ tendonitis _____
____ bursitis _____
____ arthritis _____
____ sprains/strains _____
____ low back/hip/leg pain _____
____ neck/shoulder/arm pain _____
____ headaches/head injury _____
____ spasms/cramps _____
____ jaw pain/TMJ _____
____ lupus _____

Circulatory

____ heart condition _____
____ varicose veins _____
____ blood clots _____
____ high/low blood pressure _____
____ lymphedema _____
____ breathing difficulty _____
____ sinus problems _____
____ allergies _____

Infectious Disease

____ disease name(s) _____

_____

_____

Reproductive

____ pregnant/stage _____
____ PMS _____

It is my choice to receive massage therapy. I realize the treatment is being given for the well-being of my body and mind. This includes stress reduction, relief from muscular tension, spasm or pain, or for increasing circulation or energy flow. I agree to communicate with my practitioner any time I feel like my well being is being compromised.

I understand that massage practitioners do not diagnose illness, disease or any physical or mental disorder; nor do they prescribe medical treatment, pharmaceuticals, or perform spinal thrust manipulations. I acknowledge that massage is not a substitute for medical examination or diagnosis, and that it is recommended that I see a primary health care provider for that service.

I have stated all medical conditions that I am aware of and will update the massage practitioner of any changes in my health status.

Signature _____ Date: _____