

Massage Medical Form

Name: _____

Address: _____ State: _____ Zip: _____

Home Phone: _____ Business Phone: _____

Birth date: _____ Email: _____ @ _____

Doctor: _____ Referred by: _____

Areas of Complaint, Pain or Tension: _____

Please Circle the appropriate Answer.

Have you had a professional massage before? **Yes** **No**
if yes how long ago?

Have you had surgery? **Yes** **No**
If yes describe:

Do you have any skin problems or allergies? **Yes** **No**

Do you take any prescription medications? **Yes** **No**
If yes please describe:

Have you suffered an acute injury recently? **Yes** **No**

Do you have arthritis? **Yes** **No**

Do you exercise regularly or participate in any sports? **Yes** **No**
If yes what type and how often?

Do you have any heart problems? **Yes** **No**

Do you have spinal problems? **Yes** **No**
If yes what is the diagnosis:

Are you Pregnant? **Yes** **No**

Do you have blood pressure problems? **Yes** **No**

Do you have any other problem I should be aware of before this massage? **Yes** **No**
If yes please specify:

Please Read :
 Massage Therapy is given for the purpose of stress reduction, relief from muscular tension or spasm or for increasing circulation and energy flow. I understand that the Massage therapy does not diagnose illness, disease, or any other physical or mental disorder. As such, the Massage Therapist does not prescribe medical treatment or pharmaceuticals, nor do they perform any spinal manipulations. It has been made very clear to me that this Massage Therapy is not a substitute for medical examinations and /or diagnosis and that it is recommended that I see a physician for any physical ailment that I might have. Because a Massage Therapist must be aware of existing physical conditions, I have stated all my known medical conditions and take it upon myself to keep the Massage Therapist updated on my physical health.

SIGNATURE:	DATE / /
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MESSAGE THERAPIST:	DATE / /
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