Eaton Sport & Spine Clinic: Massage Therapy
Client health history

Name: ____ Date:______________________

Address: ____ City:______________________

State: _______________________ Zip:__________________ DOB:_____________________
Phone:
Home (   )___________________ Cell (   )_______________ Work (   )_____________

E-mail: ____

Occupation: ____

Employer: ____

EMERGENCY contact:_____________________________ **Relationship:**________________

Home (   )______________ **Cell (   )**_______________ **Work (   )**________________

Referred to our office by:____

Primary Medical Health Care Provider:____

Name:____

Address: ___________________________________ City:_____________________

State: ____________________________________ Zip:______________________

Phone (   )________________________________ Fax:______________________

By initialing this, I give my Massage Therapist permission to consult with any member of my health care providers regarding my health care and treatment.
Initials:____ Date:_____________________

Health history
List any major surgeries, illnesses, or injuries and explain, please include dates and treatments received for the past 10 years.

Surgeries: ____

Injuries: ____

Illnesses: ____

___ Stress	___ Headaches	___ Fatigue
___ Fever	___ Warts	___ Cellulitis
___ Rheumatoid Arthritis	___ Varicose Veins	___Whiplash
___ Boils	___ Fungal Infections	___ Lice/mites
___ Burns	___ Fibromyalgia	___ Allergies
___ Anxiety Disorder	___Depression	___ Asthma
___ High/Low BP	___ Multiple Scleroses	___ Lupus
___ Heart Disease/ problems	___ Blood clot(s)	___ Stroke
___Diabetes	___ Dislocation	___ Tumor
___ Thyroid problems	___ Stiff/ painful joints	___ TMJ
___ Disc Disease(s)	___ Carpal Tunnel Syndrome	___ Hernia
___ Plantar Fasciitis	___ Baker Cysts	___ Gout
___ Lyme Disease	___ Poor Circulation	___ Cancer
___ Osteoporosis	___ Osteoarthritis	___Pregnant
___ Shortness of breath	___ Shooting Pain	___ Tingling
___ Numbness	___ Chemical Dependency	

___Alcoholism

___ ANY OTHER condition, disease, or syndrome that is not listed above please fill in:

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It is my choice to receive massage therapy, and I give my consent to receive massage therapy. I have reported all health conditions that I am aware of and will inform my massage therapist of any changes in my health, as they happen.

Signature: ____

Date:___________________________________