Brief Medical History (Confidential)

Name_____ Date_____
Phone (cell)_____ (home)_____ (work)_____
Age_____ Gender M_____F_____ Height_____ Weight_____ Blood Type_____
Marital Status M____S____D____W____ Number of children_____ Pregnant? Y_____ N_____
Occupation_____ Hours per workweek_____
Favorite pastime(s)_____
*Emergency contact*_____ *Phone*_____

Please list all of the following that apply to you:

Major Injuries? N____Y____ explain _____
Major Illnesses/Diseases? N____Y____ explain _____
Any Surgeries? N____Y____ explain _____
Heart conditions? N____Y____ explain _____
Liver conditions? N____Y____ explain _____
Kidney conditions? N____Y____ explain _____
Lung conditions? N____Y____ explain _____
Skin conditions? N____Y____ where? _____
Varicose Veins? N____Y____ where? _____
Osteoporosis? N____Y____ where? _____
Arthritis? N____Y____ where? _____
High___ or Low___ Blood Pressure? N____Y____ Diabetes? N____Y____ Do you bruise easily? N____Y____

Are you on any herbs/medications/prescription drugs? N___Y___ what? _____
_____

Anything else I should know about your health? N___Y___ what? _____
_____

What can I help you with (relaxation, energy, pain, injury, dysfunction, illness, etc)? _____
_____

Which type of pressure do you prefer? Deep_____ Medium_____ Light_____

I _____ ***understand*** *the application and process of massage therapy, and authorize __Chris Melmoth__ to perform massage therapy on me. I may not hold this massage therapist liable for any accidents or injuries that may occur as a result of my own negligence, including the withholding of any relative health information. I also understand that Bodyworkers/Massage Therapists are NOT doctors, and this work is in no way intended to diagnose, treat, or replace professional medical care.*

I have been informed that bruising, sore muscles, headache, and/or ill feelings are rare but can occur after treatment due to increased circulation of metabolic waste products & chemical irritants. I am encouraged to rest and drink plenty of water after the session to help prevent or minimize this unpleasantness.

Client's Signature_____ Date_____
Parent/Guardian's Signature (consent to work on a minor) _____ Date _____
Referred by_____ Your Birth Date _____/_____/_____

Health Complaint

Name _____ Date _____

Briefly explain your health issue: _____

_____

Describe your symptoms: _____

_____

When did you first notice this issue? _____

_____

If there is pain, explain where: _____

_____

How often do you feel pain? _____

Does the pain keep you up at night? No____ Yes____ explain: _____

_____

What do you believe is the cause? _____

_____

Have you received a doctor's diagnosis? No ____ Yes ____ explain: _____

_____

Are you on any drugs, herbs, or special diets? No____ Yes____ explain: _____

_____

What seems to be helping this problem? _____

_____

Anything else? _____

_____