Personal Data and Health Screen

Name ____ Date of initial visit _______________

Address ____

City ___________________________________ State ______ Zip code _________

Email ____

Referred by _____________________

Phone (day) _____________________ (eve) _____________________ Date of Birth ______________

Occupation(s) ___________________________________ Interest(s) _________________________________

What is your previous experience with professional massage/other bodywork?

What is your goal/concern for today's session?

Is there any area where you would like extra time spent, any area where you seem to hold a lot of tension? _______________________________ Any area you'd like skipped? ___________________________

Lifestyle: Nutrition ____

Exercise ____

Tobacco _________________ Alcohol __________________ Drugs (non-med.) ______________

Posture assumed most of day____

Sleep____________________ Bowels______________________ Caffeine__________________

Recreation____

Do you wear contacts ( ), dentures ( ), hearing aid ( )

Are there specific aspects of your life that are particularly stressful (job, posture, habits, diet, family, etc.)? Explain.

Medical History: (give dates)

_____ Hypertension

_____ Heart disease

_____ Arteriosclerosis

_____ Varicose veins

_____ Phlebitis

_____ Fluid retention

_____ Epilepsy

_____ Headaches

_____ Cancer/malignancy

_____ Diabetes

_____ Fractures

_____ PMS/painful menstruation

_____ Easy bruising

_____ Skin rash

_____ Abscess or open sore

_____ Skin sensitivity

_____ Allergies

_____ Herpes I or II

_____ HIV positive

_____ Other infectious diseases

_____ Mental illness

_____ Osteoporosis

_____ Osteoarthritis

_____ Rheumatoid arthritis

_____ Fibrositis

_____ Fibromyalgia

_____ Chronic Fatigue Syndrome

_____ Herniated disc

_____ Inner ear problem

_____ Pregnancy/Now

_____ Intrauterine Device

_____ Are you taking any medications? If so, what and what for?

____

Medical History: *(Continued)*

_____ Surgery/fractures (explain) (dates):

_____ Implants of any kind:

_____ Prior injuries (explain) (dates):

_____ Musculoskeletal pain/stiffness (such as low back, neck, shoulder, etc. (explain) (dates):

_____ Any other physical or health difficulties?

_____ Any difficulty lying on your back, front, or turning?

To better develop a massage/bodywork session that meets your individual needs, it will be helpful to know if you have:

_____ Any counseling history:

_____ Any history of abuse (recent or past verbal, physical, sexual, or emotional):

_____ Any recent lifestyle/emotional challenge or loss:

_____ Are you under the care of a physician or other medical practitioner now? ( ) A counselor?

For what conditions?

_____ Do we have your permission to contact your physician should the need arise?

Name of physician_________________________________ Phone______________________

This information will be treated confidentially. In order to maximize the effectiveness and safety of massage sessions together, please give your feedback during and at the end of the sessions. This will help in tailoring the massage session to serve in the best possible way.

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I have read the above information and discussed it with my practitioner. I understand that this work does not constitute medical treatment. It is a form of health and wellness maintenance utilizing the forms of traditional Swedish massage. I take responsibility for alerting my practitioner to any physical conditions that would affect this work.

Signature ____ Date _________________