Massage Therapy

Medical History Form

Name_____ Date of Birth _____

Address _____

City_____ Province_____Postal Code_____

Phone Number (___)_____Work (_____)_____

Have you ever received massage therapy?_____

Current Medications:_____

_____

Please check off any you have ever experienced or currently are experiencing:

_high blood pressure	_cancer	_sprains
_low blood pressure	_arthritis	_strains
_poor circulation	_diabetes	_constipation
_varicose veins	_migraines	_seizures
_inflammation	_headaches	_whiplash
_heart problems	_stress	_stroke
_blood clotting disorders	_sciatica	_skin conditions
_allergies_____	_bursitis	_pregnancy

Other conditions:_____

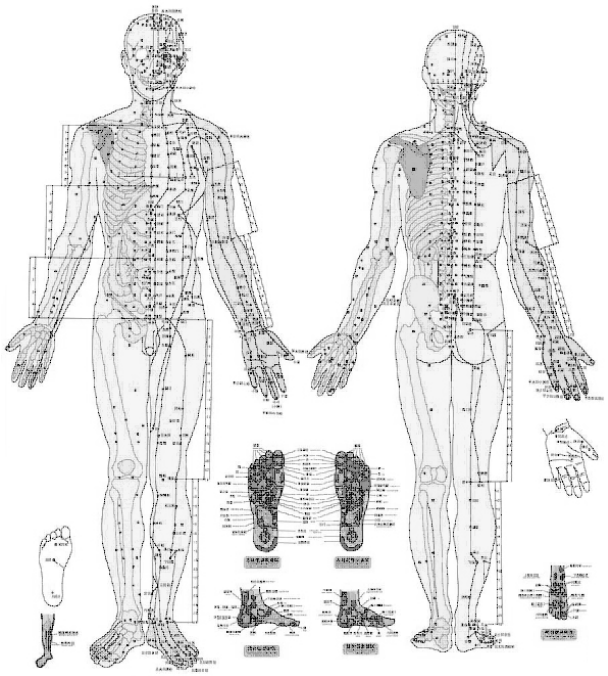
_____

_____

_____

_____.

Please indicate the area(s) where you are experiencing pain or discomfort:



How long have you been experiencing this discomfort?_____

Please indicate the level of intensity of your discomfort:

1 — 2 — 3 — 4 — 5 — 6 — 7 — 8 — 9 — 10

Any extra information you would like me to know:_____

_____

_____

_____

Please read the following closely, then sign and date.

I understand the massages given are for a therapeutic purpose to relive stress and tension in soft tissue injuries.

I understand that the massage therapist cannot diagnose or prescribe medical treatment. That it is recommended I see a medical doctor for any physical ailment and keep the massage therapist aware of my on-going physical health.

I have stated all known medical conditions and pre-existing conditions and will update, as necessary.

Signature:_____Date:_____