Inner Movement

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MASSAGE HEALTH HISTORY FORM

CLIENT INFORMATION

Name _____ Email _____

Phone (cell/day) _____ DOB _____ Age: _____

Address _____ City/State/Zip _____

Emergency Contact Name _____ Phone _____ Relationship _____

Occupation _____ Referred by: _____

HEALTH INFORMATION

	Yes	No		Yes	No		Yes	No
Anxiety / stress	☐	☐	Muscle weakness	☐	☐	Skin conditions	☐	☐
Bleeding disorder	☐	☐	Neuropathy	☐	☐	Neurological conditions	☐	☐
Blood clot	☐	☐	Osteoarthritis	☐	☐	Heart condition	☐	☐
Contagious condition	☐	☐	Osteoporosis	☐	☐	Autoimmune disorder	☐	☐
Depression	☐	☐	Phlebitis/varicose veins	☐	☐	Digestive problem	☐	☐
Diabetes	☐	☐	Rheumatoid arthritis	☐	☐	Endocrine disorder	☐	☐
Fibromyalgia	☐	☐	Sciatica	☐	☐	Respiratory disorder	☐	☐
Hearing loss	☐	☐	Seizures	☐	☐	Areas of swelling	☐	☐
Heart condition	☐	☐	Stroke / CVA	☐	☐	Frequent headaches	☐	☐
High blood pressure	☐	☐	Tuberculosis	☐	☐	Areas of numbness or decreased sensation	☐ Yes	☐ No
Low blood pressure	☐	☐	Tendinitis	☐	☐			
Kidney disease	☐	☐	TMJ disorder	☐	☐			
Multiple sclerosis	☐	☐	Vertigo / dizziness	☐	☐			
Neuropathy	☐	☐	Vision impairment	☐	☐			
Decreased sensation	☐	☐						
Are you taking blood thinners?	☐	☐						

Areas of broken skin? (e.g. rash, wounds) ☐ Yes ☐ No If yes, where? _____

Any implants? (e.g. pacemaker, insulin pump, metal) ☐ Yes ☐ No What, where? _____

Are you pregnant? ☐ Yes ☐ No If yes, how many months? _____ Due date: _____

Are you currently under medical supervision or receiving other medical interventions? ☐ Yes ☐ No

If yes, please describe: _____

Recent injuries or medical procedures in the past 2 years? ☐ Yes ☐ No Please describe: _____

Please describe any other injuries or health conditions: _____

Any allergies or hypersensitivities? (oils, lotions, nuts, fruits, skin, etc.) ☐ Yes ☐ No

If yes, please list: _____

Have you had professional massage before? ☐ Yes ☐ No How recently? _____

Reason for seeking massage:

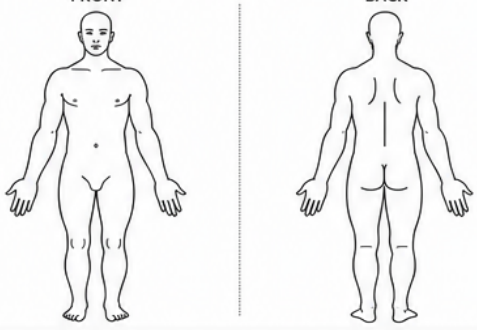
☐ Relaxation ☐ Specific problem _____

How much pressure do you prefer?

☐ Light ☐ Medium ☐ Firm

PLEASE INDICATE ANY AREAS OF PAIN OR DISCOMFORT

FRONT BACK



By signing below, I acknowledge that I have provided accurate information on this form and understand that massage therapy is not a substitute for medical care. I agree to inform my massage therapist of any changes in my health.

Client Signature _____ Date _____

Therapist Signature _____ Date _____

The information requested above will assist us in providing you with safe treatments.
Please ask your therapist if you have any questions about the information being requested.
All information provided will be kept as confidential unless allowed or required by law.
Your written permission will be required to release any information.