



An Integrated Health Resource

**CONFIDENTIAL HEALTH HISTORY
MASSAGE**

Name: _____ Date: _____

What made you decide to have a massage today? _____

Have you ever had a professional massage? Yes No If yes, when? _____

(If female) Are you pregnant? _____

Are you currently undergoing treatment for any health condition? Yes No If yes, please explain:

Current medications you are taking: _____

List any past surgeries, broken bones, major car accidents and injuries: _____

Please indicate the weekly frequency of the following substances and/or activities:

	Heavy	Moderate	Light	None
Alcohol	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Coffee	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Tea	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Tobacco	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Exercise	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Sugar	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Water	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Do you have any pain, discomfort, restricted range of motion, or difficulty performing certain actions?

Please Explain: _____

Check any areas that apply:

- | | | | |
|---|--|---|---|
| <input type="checkbox"/> Abdominal Pain | <input type="checkbox"/> Heart Attack | <input type="checkbox"/> Contagious Disease | <input type="checkbox"/> Back Pain |
| <input type="checkbox"/> AIDS | <input type="checkbox"/> Epilepsy | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Asthma |
| <input type="checkbox"/> Heart Palpitation | <input type="checkbox"/> Pinched Nerves | <input type="checkbox"/> Chest Pains | <input type="checkbox"/> Arthritis |
| <input type="checkbox"/> TMJ Dysfunction | <input type="checkbox"/> Fibromyalgia | <input type="checkbox"/> Skin Irritations | <input type="checkbox"/> Scoliosis |
| <input type="checkbox"/> Blood Pressure Low | <input type="checkbox"/> Blood Pressure High | <input type="checkbox"/> Swollen Joints | <input type="checkbox"/> Contact Lenses |