



**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:**

	<b>Heavy</b>	<b>Moderate</b>	<b>Light</b>	<b>None</b>
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 |