Confidential Medical and Personal History

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Name____ Date of Birth_____/_____/_____

Address___________________________________City_____________State____Zip___________

Home # (____)________________ Work #(____)________________Cell #(_____)_________________

Employer:_________________________________Occupation:______________________________

How did you hear about me _________________________ Email ______________________________

Current Prescription Drugs____

Current Supplements____

Please Mark any conditions you have or have had in the past:

___Abdominal Pain	___Diabetes	___Hypoglycemia	___Shingles
___Allergies/sinusitis	___Edema/swelling	___Irritable bowel	___Thrombosis
___Arthritis	___Disease of lungs	___Stomach/colon	___Thyroid problems
___Asthma	___Fibromyalgia	___Migraines/headaches	___Ulcers
___Bronchitis	___Heart Disease	___Multiple Sclerosis	___Bruise easily
___Hematomas	___Nephritis/Kidneys	___Cancer	___Hernia/rupture
___Paralysis	___Chest Pains	___High Blood Pressure	___Phlebitis
___Chronic Fatigue	___HIV or AIDS	___Varicose Veins	

Other conditions not mentioned: ____

Are you pregnant: No(__) Yes (__) If yes: Due date:____/____/____ Any miscarriages? No (_)Yes(_)

Any current health issues:________________________________ Currently on bed rest?____________

Swelling?____(where?)_____________________Pain?___(where?)________________

Doctors Name___________________________

Important surgeries & approximate dates: ____

List accidents/injuries & approximate dates:____

Physical activities or repetitive motion activities you participate in:__________________________________

What is your goal for today:____

24 HOUR CANCELLATION NOTICE IS REQUIRED, OR FULL PAYMENT IS EXPECTED.

By signing this form I am aware and agree to the cancellation notice. I will advise my massage therapist if I have any changes in my health prior to future sessions. I understand massage and bodywork is not a replacement for medical care and that no diagnosis will ever be made. I authorize release of my information to the referring doctor and/or insurance company. I understand I will be responsible for payment in full for any missed appointments not given a 24 hour cancellation.

Date:____________ **Signature:**____