



# In Tune Massage

## Confidential Health History

Name \_\_\_\_\_ Date of birth \_\_\_\_\_

Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Phone \_\_\_\_\_ Gender/pronouns \_\_\_\_\_

Email address \_\_\_\_\_

Emergency Contact Name \_\_\_\_\_ Phone number \_\_\_\_\_

How did you hear about me? Google Search \_\_\_\_ Facebook \_\_\_\_

Referred by \_\_\_\_\_ Other \_\_\_\_\_

Occupation \_\_\_\_\_

Hobbies \_\_\_\_\_

Activity level: Low Medium High

What best describes your reason for receiving a massage therapy treatment today?

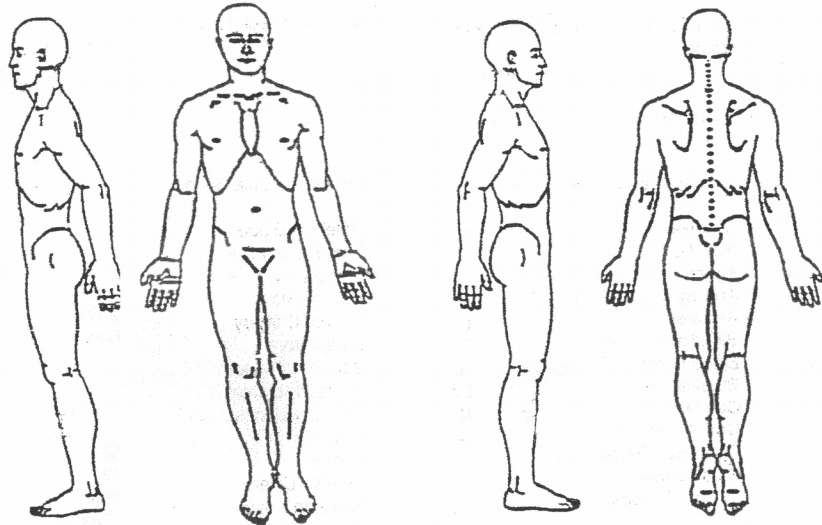
\_\_\_\_ Specific: I have a concern (i.e. recovery from injury, etc.)

\_\_\_\_ Relaxation: I need some relaxation & to de-stress

\_\_\_\_ Prevention: Stay injury and tension free

\_\_\_\_ Performance: Improve flexibility, range of motion, and athletic performance

**On the diagram, please mark areas of regular pain, stress or tension**



Have you had a professional massage before? Yes \_\_\_\_ No \_\_\_\_

If yes, what did you like? \_\_\_\_\_

What did you not like? \_\_\_\_\_

List past injuries \_\_\_\_\_

List current injuries \_\_\_\_\_

List any surgeries or hospitalizations \_\_\_\_\_

List current medications and what they are for \_\_\_\_\_

Do you have any allergies? (please list) \_\_\_\_\_

Are you currently under the care of a physician or chiropractor? \_\_\_\_\_

If yes, what for? \_\_\_\_\_

Please **CIRCLE** any **CURRENT** conditions. **UNDERLINE** any **PAST** conditions.

- |                      |                        |                             |
|----------------------|------------------------|-----------------------------|
| Anxiety              | Disc problems          | Phlebitis/Thrombosis        |
| Arthritis            | Fatigue                | Pregnant (what week? _____) |
| Arteriosclerosis     | Fibromyalgia           | Sciatica                    |
| Asthma               | Glaucoma               | Scoliosis                   |
| Back injuries        | Headaches/migraines    | Seizures/Epilepsy           |
| Blood clots          | Heart condition        | Sensitive area              |
| Bruise easily        | Hepatitis              | Skin condition              |
| Bursitis/Tendonitis  | Hiatal hernia          | Spinal injury               |
| Cancer               | High/low blood sugar   | Sprain/strain               |
| Carpal Tunnel        | Hypermobility/EDS      | Stress                      |
| Circulation problems | Hypertension           | Stroke                      |
| Concussion           | Insomnia               | TMJ disorder                |
| Contagious disease   | Mental illness         | Torn muscle/ligament        |
| Cystic Fibrosis      | Multiple Sclerosis     | Ulcer                       |
| Depression           | Neck injuries/whiplash | PTSD/CPTSD                  |
| Diabetes             | Numbness/tingling      | Other:                      |
| Digestive issues     | Osteoporosis           | _____                       |

By signing this form, I agree to the following:

1. It is my choice to receive bodywork/massage therapy. I understand that massage therapy is an aid to health and well-being, and in no way takes the place of a doctor's care when it is indicated.
2. I understand that my therapist is not qualified to diagnose, prescribe, or treat any medical condition, and that nothing said in the course of the session(s) should be construed as such.
3. I affirm that I have stated all my known medical conditions. I will let the practitioner know of any change in my medical profile, and understand that there will be no liability on the practitioner's part should I fail to do so.
4. I agree to obtain my doctor's approval prior to my first session, if necessary.
5. I understand that any inappropriate conduct by me will result in immediate termination of the session, and that I have the right to terminate the session at any time.

Signature \_\_\_\_\_

Date \_\_\_\_\_