Client Name ____

HEALTH HISTORY

Are you currently receiving treatment from a health care provider? Yes ________ No __________

If yes, list the conditions you are being treated for: ____

Health care provider's name: ____

What are your most important health concerns? ____

Have you received a professional massage? Yes ______ No ________

If yes, what depth did you receive? Light _______ Medium ______ Deep _______ Very Deep _______

Mark any condition that applies to you now or in the past. Please use **"C"** for current, **"P"** for past.

______	Osteoarthritis	______	Arm/Leg Numbness	______	Diabetes
______	Rheumatoid Arthritis	______	Phlebitis/Edema	______	Allergies/Asthma
______	Joint Replacements	______	Varicose Veins	______	Digestive Problems
______	Broken/Cracked Bones	______	Blood Clots	______	Constipation
______	Osteoporosis	______	Bruise Easily	______	Fatigue
______	Scoliosis	______	Skin Infections	______	Anxiety/Nervousness
______	Sprains/Strains	______	Contagious Conditions	______	Depression
______	Tendonitis/Bursitis	______	HIV/AIDS	______	Sleep Disorder
______	Leg Pain	______	Cancer/Tumor	______	Menopause
______	Back Pain	______	Heart Attack/Stroke	______	Sugar/Overeating Habit
______	Sciatica	______	High Blood Pressure	______	Caffeine Habit
______	Fibromyalgia	______	Low Blood Pressure	______	Alcohol/Drug Habit
______	Whiplash	______	Contact Lenses	______	Tobacco Habit
______	Headaches/Migraine	______	Pregnant (Stage ____)	______	Exercise Avoidance

MEDICAL HISTORY

Surgeries: ____

Accidents: ____

Are you allergic to any massage oils or Aromatherapy? No ________ Yes ________ (please explain below)

____

Please list Homeopathic Remedies & Supplements you are taking:

____

____

Please list Medications you are taking:

____

____

____

Anything else we should know:

____

____

____

Please circle areas of Pain/Discomfort: