Anderson Therapeutic Massage Clinic

Health History

Today's Date: _____ **DOB:** _____/_____/_____
MM DD CCYY

Client Name: _____
Last First Middle

Please answer all questions and fill in the comments
(please circle "Y" for YES and "N" for NO)

1) Have you ever had a massage by a massage therapist? ..... Y N
2) Do you have a primary care giver (MD, DO, DC)? ..... Y N
3) Do you have any recent injury or Illness? ..... Y N
If you answer yes please describe:

_____

_____

4) Do you have any skin eruption or irritations? ,,…..,,,,…….…….... Y N
5) Are you allergic to anything? ..... Y N
If yes, what?

_____

_____

6) Are you on any medications? ..... Y N
If yes, why?

_____

_____

7) Do you wear contact lenses? ..... Y N

Do you have or have you ever had any of the following

- ☐ Aids
- ☐ Arthritis
- ☐ Bad Posture
- ☐ Blood Clots
- ☐ Bruise easily
- ☐ Bursitis
- ☐ Cancer
- ☐ Chronic Pain
- ☐ Diabetes
- ☐ Fever
- ☐ Heart Disease
- ☐ Hernia
- ☐ Herniated Disk
- ☐ Hyper Tension
- ☐ MS __Tendonitis
- ☐ Pain in the Abdomen
- ☐ Polio
- ☐ Sciatica
- ☐ Scoliosis
- ☐ Stroke
- ☐ Varicose Veins
- ☐ Others

Comments:
(Any concerns I should know about, as well as any effects from the last massage that you had.)

_____

_____

_____

Signature: _____ **Date:** _____

Name: _____ **Date:** _____

Updated: 02/02/12 TA/JMB