



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

- | | | | |
|--|--|---|---|
| <input type="checkbox"/> Aids | <input type="checkbox"/> Cancer | <input type="checkbox"/> Herniated Disk | <input type="checkbox"/> Scoliosis |
| <input type="checkbox"/> Arthritis | <input type="checkbox"/> Chronic Pain | <input type="checkbox"/> Hyper Tension | <input type="checkbox"/> Stroke |
| <input type="checkbox"/> Bad Posture | <input type="checkbox"/> Diabetes | <input type="checkbox"/> MS <input type="checkbox"/> Tendonitis | <input type="checkbox"/> Varicose Veins |
| <input type="checkbox"/> Blood Clots | <input type="checkbox"/> Fever | <input type="checkbox"/> Pain in the Abdomen | <input type="checkbox"/> Others |
| <input type="checkbox"/> Bruise easily | <input type="checkbox"/> Heart Disease | <input type="checkbox"/> Polio | |
| <input type="checkbox"/> Bursitis | <input type="checkbox"/> Hernia | <input type="checkbox"/> Sciatica | |

Comments:

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

Signature: _____ Date: _____

Name: _____ Date: _____