MASSAGE IS MEDICINE

Health History Form

Diana R. Sponsler, LMT

Name_____Date of Birth _____

Address_____

City _____State_____Zip_____

Work Ph._____Home Ph._____Cell Ph._____

e-mail address: _____

Occupation _____

Are you currently being treated by a physician?_____

For what purpose _____

List medications currently taking _____

List any surgeries and when _____

List any prostheses, pins, bars, implants, etc. _____

Do you have specific pain you wish treated? Yes / No

*Does your pain radiate?*_____*Where?*_____

Are you pregnant or trying to become pregnant? Yes / No Due Date_____

Are you allergic to any nut oils? Yes/No if Yes, please list_____

Are you allergic to latex? Yes / No

Have you had any lymph nodes removed? Yes/No (where?)_____

Please check the following conditions you have or have had:

arthritis	☐	asthma	☐	fractures	☐
disc problems	☐	cancer	☐	neck pain	☐
diabetes	☐	poor circulation	☐	high blood pressure	☐
low blood pressure	☐	chest pain	☐	sciatica	☐
immune disorder	☐	blood clots	☐	osteoporosis	☐
heart condition	☐	phlebitis	☐	headaches	☐
kidney condition	☐	sinus problems	☐	edema	☐
liver condition	☐	varicose veins	☐	skin disorders	☐
epilepsy	☐	bruise with light pressure	☐	numbness	☐
fatigue	☐	limited movement	☐	pinched nerves	☐
swollen joints	☐	chronic cough	☐	depression	☐
other	☐	_____			

I understand the above information is strictly confidential and is used to help the massage therapist determine any indications or contraindications for massage. I understand that the services provided are not a replacement for medical or psychological care, and that any information provided is not prescriptive or diagnostic in nature, and is for eductional purposes only. Any exchange between therapist and client during a session will be kept confidential. I agree that I am responsible for all charges incurred and will make payment when requested.

I give permission to contact my doctor if indicated: ☐

Name of Doctor _____ Phone: _____

Signature_____ Date: _____