



MESSAGE HEALTH SCREEN

NAME _____ DATE OF INITIAL VISIT _____

STREET _____

CITY, STATE, ZIPCODE _____

DATE OF BIRTH _____ REFERRED BY _____

E-MAIL _____ CELL PHONE# _____

WORK PHONE# _____ HOME PHONE# _____

OCCUPATION _____

INTEREST(S) _____

What is your previous experience with professional massage/other bodywork?

What is your goal/concern for today's session?

Is there any area where you would like extra time spent, any area where you seem to hold a lot of tension?

Any area you would like skipped?

Lifestyle:

Nutrition _____ Exercise _____

Tobacco _____ Alcohol _____ Drugs(non-med) _____

Posture assumed most of the day _____

Sleep _____ Bowels _____ Caffeine _____

Recreation _____

Do you wear contacts _____ dentures _____ hearing aid _____

Are there specific aspects of your life that are particularly stressful (job, posture, habits, diet, family, etc)?

Explain.

Please See Page Two





Medical History: (Give dates)

- | | | | |
|---|--|---|---|
| <input type="checkbox"/> Hypertension | <input type="checkbox"/> Mental Illness | <input type="checkbox"/> allergies | <input type="checkbox"/> chronic fatigue |
| <input type="checkbox"/> Heart disease | <input type="checkbox"/> easy bruising | <input type="checkbox"/> herpes I or II | <input type="checkbox"/> syndrome |
| <input type="checkbox"/> Arteriosclerosis | <input type="checkbox"/> skin rash | <input type="checkbox"/> other infectious | <input type="checkbox"/> herniated disc |
| <input type="checkbox"/> Varicose veins | <input type="checkbox"/> abscess or open | <input type="checkbox"/> diseases | <input type="checkbox"/> PMS/painful menstruation |
| <input type="checkbox"/> Phlebitis | <input type="checkbox"/> sore | <input type="checkbox"/> pregnancy/now | <input type="checkbox"/> osteoporosis |
| <input type="checkbox"/> Fluid retention | <input type="checkbox"/> skin sensitivity | <input type="checkbox"/> intra uterine device | <input type="checkbox"/> osteoarthritis |
| <input type="checkbox"/> Epilepsy | <input type="checkbox"/> Headaches | <input type="checkbox"/> inner ear problem | <input type="checkbox"/> rheumatoid arthritis |
| <input type="checkbox"/> Fractures | <input type="checkbox"/> Cancer/malignancy | <input type="checkbox"/> fibromyalgia | <input type="checkbox"/> other _____ |
| | <input type="checkbox"/> Diabetes | <input type="checkbox"/> fibrositis | |

Any difficulty lying on your back, front or turning?

Are you taking any medicines? If so, what and what for?

Surgery/fractures (explain)(dates):

Implants of any kind:

Prior injuries (explain)(dates):

Musculoskeletal pain/stiffness (such as low back, neck, shoulder, etc.)(explain)(dates):

Any other physical or health difficulties:

To better develop a massage/bodywork session that meets your individual needs, it will be helpful to know if you have:

Any counseling history:

Any history of abuse (recent or past verbal, physical, sexual, emotional):

Any recent lifestyle/emotional challenge or loss:

Are you under the care of a physician or other medial practitioner now? A counselor?
For what condition(s):





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_____ Do we have your permission to contact your physician should the need arise?

Name of Physician _____ Phone _____

This information will be treated confidentially. In order to maximize the effectiveness and safety of massage sessions together, please give your feedback during and at the end of the sessions. This will help in tailoring the massage session to serve in the best possible way.

I have read the above information and discussed it with my practitioner. I understand that this work does not constitute medical treatment. It is a form of health and wellness maintenance utilizing the techniques of traditional Swedish massage. I take responsibility for alerting my practitioner to any physical, mental, or emotional conditions that would affect this work.

Signature _____ Date _____

(If client is a minor, parent/guardian sign above)

