

Date: _____ Patient: _____ Chart#: _____

Massage History/Treatment Information

Have you ever received a professional massage? Yes No If yes, frequency _____
Date of last massage _____

What result do you want from your massage sessions? _____

Please check the areas of your body that you give permission to receive massage:
back legs buttocks arms abdomen chest neck head face

Are you currently seeing a medical practitioner? Please explain if yes. Yes No

List current medications, including aspirin, ibuprofen, etc.

Previous History (Include year and treatment received)

Surgeries:

Accidents/Injuries:

It is my choice to receive massage therapy. I realize that the treatment is being given for the well-being of my body and mind. This includes stress reduction, relief from muscular tension, spasm or pain, or for increasing circulation or energy flow. I agree to communicate with my practitioner any time I feel like my well-being is being compromised.

I understand that massage practitioners do not diagnose illness, disease, or any physical or mental disorder; nor do they prescribe medical treatment, pharmaceuticals, or perform spinal thrust manipulations. I acknowledge that massage is not a substitute for medical examination or diagnosis, and that it is recommended that I see a primary health care provider for that service.

I have stated all medical conditions that I am aware of and will update the massage practitioner of any changes in my health status.

SIGNATURE: _____ DATE: _____