Medical History

Name: (first) _____ (middle) _____ (last) _____

Home Address: _____ City, Zip _____

Phone: (daytime) _____ (home) _____ (cell) _____

Birth date: _____ Marital Status: ☐ Married ☐ Single ☐ Divorced ☐ Partnered

Occupation: _____ Employer: _____

Referred by: _____

Insurance Name and Policy Number: _____

_____

Emergency Contact: Name: _____ Phone: _____

Physician: Name: _____ Phone: _____

Massage Information:

First Professional Massage: ☐ Yes ☐ No; how frequently do you have a massage: _____

Medical Information:

List accidents/injuries, hospitalizations and surgeries: when they occurred and treatment received:

_____

_____

_____

Any lingering effects from the above or do you feel you have recovered:

_____

_____

Chronic, ongoing pain?: ☐ No ☐ Yes, please describe and any care or treatment you receive:

_____

_____

_____

Do activities affect the pain? ☐ No ☐ Yes, please describe:

_____

_____

_____

Are you currently being treated medically or taking prescribed drugs? ☐ No ☐ Yes, please describe:

_____

_____

_____

(OVER)