



125 E. Trinity Place, Suite 208
Decatur, GA 30030
404.784.2225

PERSONAL HEALTH HISTORY

Name	Date
Address	Referred by
	Date of last massage
	How often do you receive massages?
Day Phone	Goals for massage sessions:
Evening Phone	
Mobile Phone	
Occupation	
Date of Birth	
Emergency Contact	
Emergency Contact Phone	

Check all items that apply:

Muscular/Skeletal:	Circulatory/Respiratory:	Skin:	Nervous/Endocrine:
Low back, hip, or leg pain <input type="checkbox"/>	Heart condition <input type="checkbox"/>	Allergies <input type="checkbox"/>	Chronic pain <input type="checkbox"/>
Neck, shoulder, arm pain <input type="checkbox"/>	Varicose veins <input type="checkbox"/>	Rashes <input type="checkbox"/>	Fatigue <input type="checkbox"/>
Headaches/head injuries <input type="checkbox"/>	Blood clots <input type="checkbox"/>	Acne <input type="checkbox"/>	Sleeping disorder <input type="checkbox"/>
Spasms or cramps <input type="checkbox"/>	Aneurysm <input type="checkbox"/>	Athletes foot <input type="checkbox"/>	Numbness/tingling <input type="checkbox"/>
Jaw pain/TMJ problems <input type="checkbox"/>	Phlebitis <input type="checkbox"/>	Warts <input type="checkbox"/>	Herpes/shingles <input type="checkbox"/>
Sprains/Strains <input type="checkbox"/>	High blood pressure <input type="checkbox"/>	Bruises <input type="checkbox"/>	Diabetes <input type="checkbox"/>
Tendentious <input type="checkbox"/>	Low blood pressure <input type="checkbox"/>	Other skin conditions <input type="checkbox"/>	Thyroid problems <input type="checkbox"/>
Bursitis <input type="checkbox"/>	Lymphedema <input type="checkbox"/>	Gastrointestinal:	Other:
Broken/Fractured bones <input type="checkbox"/>	Breathing difficulties <input type="checkbox"/>	Diverticulitis <input type="checkbox"/>	Cancer/tumors <input type="checkbox"/>
Bone or joint disease <input type="checkbox"/>	Sinus problems <input type="checkbox"/>	Irritable bowel syndrome <input type="checkbox"/>	Hernia <input type="checkbox"/>
Arthritis (RA, osteo, etc) <input type="checkbox"/>	Allergies <input type="checkbox"/>	Constipation <input type="checkbox"/>	Caffeine addiction <input type="checkbox"/>
Lupus <input type="checkbox"/>	Other circulatory/ respiratory <input type="checkbox"/>	Gas/Bloating <input type="checkbox"/>	Nicotine addiction <input type="checkbox"/>
Fibromyalgia <input type="checkbox"/>		Eating disorder <input type="checkbox"/>	Drug/alcohol addiction <input type="checkbox"/>
Other muscular/skeletal <input type="checkbox"/>		Other GI problems <input type="checkbox"/>	Infectious disease(s) <input type="checkbox"/>
			Other (explain below) <input type="checkbox"/>

Please elaborate on items checked above. Include brief history of surgeries, severe illnesses and accidents (include year and treatment). Use back as needed.

List current medications (include over-the-counter, i.e. aspirin, etc.)

List all health care professionals currently being consulted

Note relaxation and exercise activities and frequency

How do you generally feel? Are there areas where stress appears?

Release: I understand that my appointment time is reserved exclusively for me. I agree to provide 24 hours notice of cancellation or pay for the missed appointment. I have provided all pertinent information of which I am aware at this time. If conditions change, I understand that it is my responsibility to update the massage therapist. I understand that all information provided is confidential. I understand that massage therapists do not diagnose or prescribe treatments for neither physical nor mental disorders, prescribe pharmaceuticals, nor perform spinal thrust manipulations.

Signature: _____

Date: _____