Personal Health Information

Name: _____ **DOB:** _____

Address: _____

Phone (c): _____ **(h):** _____ **Email:** _____

EmergencyContact: _____ **Phone:** _____

1. **Have you had Massage Therapy before?** Yes ☐ No ☐ (If Yes, what did you particularly like or dislike?)

2. **How would you like massage to support you?**

3. **Please check the areas that you would like to receive massage to** (check box):

☐ back ☐ arms/hands ☐ legs ☐ feet ☐ face ☐ chest ☐ scalp ☐ neck

4. **General Signs and Symptoms** (check Yes and add comments if you have any of the following):

	Yes	Comments
A. Are there any areas you **protect**?		
B. Any **pain** or **tenderness**?		
C. Any **numbness** or **reduced sensation**?		
D. Any areas that are **warm or red**?		
E. Any **swelling** or **tendency** to swell?		
F. Fatigue		

5. **Specific Medical Conditions** (please include dates):

	Yes	Comments
A. **Skin conditions**		

B. A**llergies or sensitivities** (if you use any special lotion, feel free to bring it)		
C. **Cancer** (please describe the type of cancer and location)		
D. **Liver or kidney conditions**		
E. **Respiratory or lung condition**s (such as emphysema or asthma)		
F. **Cardiovascular conditions** (history of heart condition, high blood pressure, angina, stroke, varicose veins, **blood clots**)		
G. **Diabetes** (describe the type, any complications, whether blood sugar is well-controlled)		
H. **Bone or joint problems** (such as osteoporosis, arthritis or bone metastasis)		
I. **Digestive problems** (such as colitis, IBS, constipation, or diarrhea)		
J. **Injuries** (such as, accidents, tendonitis, fractures)		
K. **Autoimmune** (such as lupus, chronic fatigue syndrome, or fibromyalgia)		
L. **Hematological conditions** (such as anemia, low white blood count, low platelets)		
M. **Other**		

6. **Surgical Procedures** (please include dates):

a. Please list surgeries or surgical procedures. If lymph nodes were tested as part of the process, please describe the area(s) from which they were removed.

7. **Medications, including chemotherapies** (past and present chemos if possible). Please list the reason for the medication:

Drug	Reason for taking	Side effects you are experiencing from the drug

8. **List other medical treatments,** such as radiation or physical therapy (please include dates):

9. **Do you have any <u>SITES</u> to be mindful of due to** (check box):

☐ incision/wound ☐ radiation site ☐ neuropathy ☐ skin sensitivity/condition
☐ fracture history ☐ tumor site ☐ medical device ☐ area of infection ☐ other

Please describe:

10. **Are you experiencing any of the following** (check box):

☐ history or risk of lymphedema	☐ recent surgery	☐ infection or fever
☐ area of pain	☐ swelling	☐ risk of easy bruising
☐ pain medication	☐ fragile bones	☐ fatigue
☐ fragile / sensitive skin	☐ nausea	☐ other

Please describe:

11. **Do you have any <u>POSITIONING</u> needs due to** (check box):

☐ incision	☐ swelling	☐ medical device	☐ difficulty breathing
☐ discomfort	☐ tumor sites	☐ nausea	☐ other

Please describe:

12. **Describe your activity level** (include information about work, exercise, interests or hobbies):

I realize that this session is being given for the purpose of relaxation and comfort. I agree to communicate with the therapist anytime that I am uncomfortable or that I feel my well-being is compromised. I have listed all of the medical conditions that I am aware of.

My doctor is aware that I receive massage. Yes ☐ No ☐

Signature _____ Date _____