*Have you had a massage in the past?*___________________________________

What kind of pressure do you prefer? Light Medium Firm

What are your goals/expected outcomes for receiving massage?

How do you feel today?

List and prioritize your current symptoms/issues (stress, pain, stiffness, numbness/tingling, swelling, etc.):

Do these symptoms interfere with your daily living (e.g. sleep, exercise, work, childcare, etc.) Yes No
Explain:

List the medications you currently take:

Are you wearing contacts? ☐ *Yes* ☐ *No*
Are you wearing dentures? ☐ *Yes* ☐ *No*
Are you wearing a hairpiece? ☐ *Yes* ☐ *No*
Are you pregnant? ☐ *Yes* ☐ *No*

Health History:
Have you had any injuries or surgeries in the past that may influence today's treatment?

CHECK ANY of the following health conditions that you currently have (if you are unsure please ask):
☐ *Blood Clots* ☐ *Infections* ☐ *Congestive heart failure* ☐ *Contagious Diseases* ☐ *Pitted Edema*

PLEASE INDICATE conditions that you have or have had in the past. Explain in detail, include previous treatment
☐ *Current* ☐ *Past* *Muscle or joint pain* __________
☐ *Current* ☐ *Past* *Muscle of joint stiffness* __________
☐ *Current* ☐ *Past* *Numbness or tingling* __________
☐ *Current* ☐ *Past* *Swelling* __________
☐ *Current* ☐ *Past* *Bruise easily* __________
☐ *Current* ☐ *Past* *Sensitive to touch/pressure* __________
☐ *Current* ☐ *Past* *High/Low Blood Pressure* __________
☐ *Current* ☐ *Past* *Stroke/Heart Attack* __________
☐ *Current* ☐ *Past* *Varicose Veins* __________
☐ *Current* ☐ *Past* *Shortness of breath, asthma* __________
☐ *Current* ☐ *Past* *Cancer* __________
☐ *Current* ☐ *Past* *Neurological (e.g. MS, Parkinson's, chronic pain* __________
☐ *Current* ☐ *Past* *Epilepsy, Seizures* __________
☐ *Current* ☐ *Past* *Migraines/Headaches* __________
☐ *Current* ☐ *Past* *Dizziness, ringing in ears* __________
☐ *Current* ☐ *Past* *Digestive Conditions* __________
☐ *Current* ☐ *Past* *Gas, Bloating, constipation* __________
☐ *Current* ☐ *Past* *Kidney/Gallbladder/Prostate* __________
☐ *Current* ☐ *Past* *Arthritis/rheumatoid/osteo* __________
☐ *Current* ☐ *Past* *Scoliosis* __________
☐ *Current* ☐ *Past* *Broken Bones* __________
☐ *Current* ☐ *Past* *Allergies* __________
☐ *Current* ☐ *Past* *Diabetes* __________
☐ *Current* ☐ *Past* *Endocrine/Thyroid* __________
☐ *Current* ☐ *Past* *Depression/anxiety* __________
☐ *Current* ☐ *Past* *Memory Loss, confusion, easily overwhelmed* __________