

**Massage Therapy Health Form**

Name \_\_\_\_\_ Date \_\_\_\_\_  
Address \_\_\_\_\_  
City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_ Age \_\_\_\_\_  
Date of Birth \_\_\_\_\_ Home Phone \_\_\_\_\_ Cell phone \_\_\_\_\_  
E-mail \_\_\_\_\_ Occupation \_\_\_\_\_  
Are you currently being treated by a Physician? \_\_\_\_\_  
If yes, what for? \_\_\_\_\_  
List any medications currently taking \_\_\_\_\_  
Any recent surgeries? \_\_\_\_\_  
Do you have specific pain you wish treated? \_\_\_\_\_  
Are you pregnant or trying to become pregnant? \_\_\_\_\_  
Are you allergic to any nut oils, or essential oils? \_\_\_\_\_  
If yes, please list \_\_\_\_\_  
Have you ever had a Massage before? \_\_\_\_\_

**Please check the following conditions you HAVE or EVER HAD:**

- |                           |                        |
|---------------------------|------------------------|
| _____ Arthritis           | _____ Neck pain        |
| _____ Asthma              | _____ Fractures        |
| _____ Cancer              | _____ Disc Problem     |
| _____ Diabetes            | _____ Poor Circulation |
| _____ High Blood Pressure | _____ Chest Pain       |
| _____ Low Blood Pressure  | _____ Sciatica         |
| _____ Constipation        | _____ Blood Clots      |
| _____ Osteoporosis        | _____ Phlebitis        |
| _____ Heart Condition     | _____ Headaches        |
| _____ Kidney Condition    | _____ Sinus condition  |
| _____ Liver Condition     | _____ Edema            |
| _____ Varicose Veins      | _____ Skin disorder    |
| _____ Epilepsy            | _____ Bruise easily    |
| _____ Fatigue             | _____ Numbness         |
| _____ Limited Movement    | _____ Depression       |
| _____ Swollen Joints      | _____ Chronic Cough    |
| _____ Pinched Nerves      | _____ Other            |

**I understand the above information is strictly confidential and is used to help the massage therapist determine any indication/contraindications for the massage. I understand that receiving the massage does not take the place of medical treatment and I release Jackie Santulli of A Better Massage or any License Massage Therapist working under A Better Massage from any liability that may occur as a result of the session.**

**Client Signature** \_\_\_\_\_

**LMT Signature** \_\_\_\_\_