RMT HEALTH HISTORY FORM

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Name:_____ Phone # _____

EMAIL: _____

Address: _____

Occupation: _____ Date of Birth: _____

How did you hear about us? _____

The following information will be used to help plan safe and effective massage sessions:
Please answer to the best of your knowledge.

1. Have you had a professional massage before? Yes ☐ No ☐

   If yes, how often do you receive massage therapy? _____

2. Do you have difficulty lying on your front, back or side? Yes ☐ No ☐

   If yes, please explain: _____

3. Do you have any allergies to oils, lotions, or ointments? Yes ☐ No ☐

   If yes, please explain: _____

4. Do you have sensitive skin? Yes ☐ No ☐

5. Are you wearing: contact lenses ☐ dentures ☐ hearing aid ☐

6. Do you sit for long hours at a workstation, computer, or when driving? Yes ☐ No ☐

   If yes, please explain: _____

7. Do you perform any repetitive movements in your work, sports, or hobby? Yes ☐ No ☐

   If yes, please explain: _____

8. Do you experience stress in your work, family, or other aspects of your life? Yes ☐ No ☐

   If yes, how do you think it has affected your health?

   Muscle Tension ☐ Anxiety ☐ insomnia ☐ irritability ☐ other ☐ _____

9. Is there a particular area of the body where you are experiencing tension, stiffness, pain or other discomfort?

   Yes ☐ No ☐

   If yes, please identify: _____

10. Do you suffer from chronic pain? Yes ☐ No ☐

    If so, please explain: _____

    What makes it better? _____

    What makes it worse? _____

11. Have you had any orthopedic injuries? Yes ☐ No ☐

    If yes, please list: _____

12. Have you had any surgeries? Yes ☐ No ☐

    If yes, please list: _____

13. Are you currently under medical supervision? Yes ☐ No ☐

    If so, please explain: _____

14. Do you see a Chiropractor? Yes ☐ No ☐ If yes, how often? _____

15. Are you currently taking any medications? Yes ☐ No ☐

    If yes, please list: _____

16. Please check any conditions listed below that applies to you:

Contagious skin Condition ☐	High or low blood pressure ☐	Cancer ☐
Open sores or wounds ☐	Circulatory disorder ☐	Diabetes ☐
Easy bruising ☐	Atherosclerosis ☐	Decreased sensation ☐
Recent accident or injury ☐	Phlebitis ☐	Back / Neck problems ☐
Artificial joints ☐	Deep vein thrombosis / blood clots ☐	Fibromyalgia ☐
Sprains / Strains ☐	Joint disorders / Rheumatoid arthritis ☐	TMJ ☐
Current fever ☐	Osteoarthritis / Tendonitis ☐	Carpal tunnel syndrome ☐
Swollen glands ☐	Osteoporosis ☐	Tennis elbow ☐
Allergies / Sensitivity ☐	Epilepsy ☐	Recent surgery ☐
Digestive Issues ☐	Headaches / Migraines ☐	Pregnancy ☐
Heart Condition ☐		If yes, how many months ☐

Please explain any condition that you have marked above: _____

_____

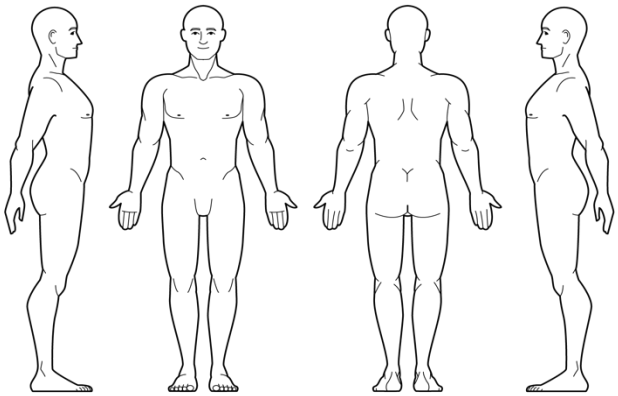
17. Do you have any particular goals in mind for this massage session? Yes ☐ No ☐

If yes, please explain

18. Is there anything else about your health history that you think might be useful for your massage practitioner to know to plan a safe and effective massage session for you? _____

_____

Once printed, Please circle all areas of discomfort



By signing below, you agree to the following:

I have completed this form to the best of my ability and knowledge and agree to inform my therapist if any of the above information changes at any time

Client signature: _____ Date: _____

Therapist Signature _____ Date: _____

Cancellation Policy:

We require 24 hours' advanced notice. Same-day cancellations or missed/no-show appointments will result in a charge for the full amount of your scheduled appointment. If you are late for your appointment, treatment will be shortened by that amount, and you will be charged for the full scheduled appointment. In an event of an unforeseeable emergency, late cancellation, missed / no-show fees will not apply.

I have read and agree to the cancellation policy above_____ date: _____

Signature of client