

MESSAGE IS MEDICINE

Health History Form
Diana R. Sponsler, LMT

Name _____ Date of Birth _____

Address _____

City _____ State _____ Zip _____

Work Ph. _____ Home Ph. _____ Cell Ph. _____

e-mail address: _____

Occupation _____

Are you currently being treated by a physician? _____

For what purpose _____

List medications currently taking _____

List any surgeries and when _____

List any prostheses, pins, bars, implants, etc. _____

Do you have specific pain you wish treated? Yes / No

Does your pain radiate? _____ Where? _____

Are you pregnant or trying to become pregnant? Yes / No Due Date _____

Are you allergic to any nut oils? Yes/No if Yes, please list _____

Are you allergic to latex? Yes / No

Have you had any lymph nodes removed? Yes/No (where?) _____

Please check the following conditions you have or have had:

arthritis	<input type="checkbox"/>	asthma	<input type="checkbox"/>	fractures	<input type="checkbox"/>
disc problems	<input type="checkbox"/>	cancer	<input type="checkbox"/>	neck pain	<input type="checkbox"/>
diabetes	<input type="checkbox"/>	poor circulation	<input type="checkbox"/>	high blood pressure	<input type="checkbox"/>
low blood pressure	<input type="checkbox"/>	chest pain	<input type="checkbox"/>	sciatica	<input type="checkbox"/>
immune disorder	<input type="checkbox"/>	blood clots	<input type="checkbox"/>	osteoporosis	<input type="checkbox"/>
heart condition	<input type="checkbox"/>	phlebitis	<input type="checkbox"/>	headaches	<input type="checkbox"/>
kidney condition	<input type="checkbox"/>	sinus problems	<input type="checkbox"/>	edema	<input type="checkbox"/>
liver condition	<input type="checkbox"/>	varicose veins	<input type="checkbox"/>	skin disorders	<input type="checkbox"/>
epilepsy	<input type="checkbox"/>	bruise with light pressure	<input type="checkbox"/>	numbness	<input type="checkbox"/>
fatigue	<input type="checkbox"/>	limited movement	<input type="checkbox"/>	pinched nerves	<input type="checkbox"/>
swollen joints	<input type="checkbox"/>	chronic cough	<input type="checkbox"/>	depression	<input type="checkbox"/>
other	<input type="checkbox"/>	_____			

I understand the above information is strictly confidential and is used to help the massage therapist determine any indications or contraindications for massage. I understand that the services provided are not a replacement for medical or psychological care, and that any information provided is not prescriptive or diagnostic in nature, and is for educational purposes only. Any exchange between therapist and client during a session will be kept confidential. I agree that I am responsible for all charges incurred and will make payment when requested.

I give permission to contact my doctor if indicated:

Name of Doctor _____ Phone: _____

Signature _____ Date: _____