



# Massage Therapy Works inc.

## Health History Form

Check this box if this is your first massage.  
If no, when was your most recent massage?  
\_\_\_\_\_

Some of our therapists use essential oils. Are you scent sensitive? \_\_\_\_\_

Any allergies, such as nut-based oils? Which?  
\_\_\_\_\_  
\_\_\_\_\_

Anything else you want us to know? \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**Please check off any of the following health conditions and note whether current or past:**

- |   |  |   |
|---|--|---|
| <input type="checkbox"/> Arthritis: _____           | <input type="checkbox"/> Heart Disease: _____        | <input type="checkbox"/> Seizures: _____                |
| <input type="checkbox"/> Asthma: _____              | <input type="checkbox"/> High Blood Pressure: _____  | <input type="checkbox"/> Severe Menstrual Cramps: _____ |
| <input type="checkbox"/> Bursitis: _____            | <input type="checkbox"/> Infections (current): _____ | _____   |
| <input type="checkbox"/> Cancer: _____              | <input type="checkbox"/> Kidney Issue: _____         | <input type="checkbox"/> Sinus Pressure: _____          |
| <input type="checkbox"/> Concussion: _____          | <input type="checkbox"/> Liver Issue: _____          | <input type="checkbox"/> Skin Issue: _____              |
| <input type="checkbox"/> Diabetes: _____            | <input type="checkbox"/> Low Blood Pressure: _____   | <input type="checkbox"/> Vertebral Issue: _____         |
| <input type="checkbox"/> Digestive Disorders: _____ | <input type="checkbox"/> Migraines: _____            | <input type="checkbox"/> Whiplash: _____                |
| <input type="checkbox"/> Dizziness: _____           | <input type="checkbox"/> Nausea: _____               | <input type="checkbox"/> Other: _____                   |
| <input type="checkbox"/> Headaches: _____           | <input type="checkbox"/> Pins/Staples: _____         | <input type="checkbox"/> Other: _____                   |

### Treatment Upgrade Authorization

Massage Therapy Works specializes in many levels of bodywork, each suited to different needs and goals of our clients. If you are dealing with a muscle strain from sitting all day in front of a computer, a recent injury, or a chronic pain, you are likely to see greater results with a clinically-focused approach such as *Integrative Bodywork*, *Deep Tissue Massage*, *Rehab Myotherapy* or *Biofield Tuning*.

If you chose a *Stress Reduction Massage*, please be aware that this is a soothing treatment using relatively light pressure and is not designed to resolve muscle tension issues such as knots and pain.

If you selected *Therapeutic Massage* for today's session and during the initial discussion your therapist feels that a more clinical approach would better achieve your goal of greater movement and less pain, you will have the option to upgrade to a different service.

### Please select one of the following statements:

- I authorize my therapist to upgrade to whichever service they feel is most appropriate and in my best interest for achieving my goal. (NOTE: There will be an additional cost so please refer to our price list.)
- I think I prefer to stay with *Therapeutic Massage* at least for my first visit but I'm open to suggestion.
- At this time I am only interested in *Stress-Reduction Massage*, not deep pressure or clinical bodywork.

By signing I am acknowledging that I have filled out this form to the best of my ability and that the information I provided is accurate. I have read and agree to the **Terms and Conditions** including the **24-hour cancellation policy**.

\_\_\_\_\_  
Your Signature

\_\_\_\_\_  
Date



# Massage Therapy Works inc.

## Health History Form

12/2016

Name: \_\_\_\_\_ Date of Birth: \_\_\_\_/\_\_\_\_/\_\_\_\_ Age: \_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Primary Phone: \_\_\_\_\_ Is this a cell phone? (Y/N) Secondary Phone: \_\_\_\_\_

Email: \_\_\_\_\_ (For appt. confirmations, reminders & communication.)

Please add me to your last-minute contact list for discounts and promotions via Email

### How did you hear about us?

<input type="checkbox"/> Gift Certificate	<input type="checkbox"/> Outside Sign	<input type="checkbox"/> Doctor/Chiropractor	<input type="checkbox"/> Friend/Family: _____ (full name)	<input type="checkbox"/> Google	<input type="checkbox"/> Yelp!	<input type="checkbox"/> Scout Magazine
---	---------------------------------------	--	---	---------------------------------	--------------------------------	---

Current Occupation: \_\_\_\_\_

Previous Occupation: \_\_\_\_\_

Current Exercise/Sports: \_\_\_\_\_

Previous Exercise/Sports: \_\_\_\_\_

Are you pregnant? How many weeks? \_\_\_\_\_

Play(ed) musical instrument? Which? \_\_\_\_\_

If so, any complications? \_\_\_\_\_

Stand still for 3+ hours a day?

Rate your current stress level: 1 2 3 4 5

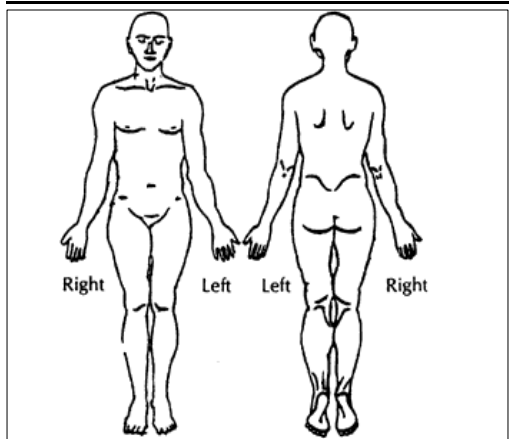
Daily computer use? \_\_\_\_\_ Standing desk? \_\_\_\_\_

### Reason(s) for today's appointment?

Drive 2+ hours a day? \_\_\_\_\_ Ride to work? \_\_\_\_\_

<input type="checkbox"/> Need some Relaxation	<input type="checkbox"/> Stress/Anxiety	<input type="checkbox"/> Chronic Pain	<input type="checkbox"/> Headaches/Migraines	<input type="checkbox"/> Sports Injury	<input type="checkbox"/> Pre/Post Natal	<input type="checkbox"/> Post Surgery	<input type="checkbox"/> Other: _____
<input type="checkbox"/> Jaw Pain	<input type="checkbox"/> Neck Pain	<input type="checkbox"/> Shoulder Pain	<input type="checkbox"/> Back Pain	<input type="checkbox"/> Hip Pain	<input type="checkbox"/> Knee Pain	<input type="checkbox"/> Ankle/Foot Pain	<input type="checkbox"/> Wrist/Hand Pain

Describe all injuries and surgeries: \_\_\_\_\_



Have you ever been in an automobile (or bicycle) accident? Were you injured? \_\_\_\_\_

Which areas of your body tighten up when you're active or stressed? \_\_\_\_\_

How would you describe your posture? \_\_\_\_\_

Fine  Not Great  Horrible \_\_\_\_\_

1. Circle your areas of pain
2. Put an X where you feel muscle tension
3. Put an N where you feel any numbness

**Please turn over and fill out page 2**