CEDAR OAK
IN-HOME MASSAGE

Date_____

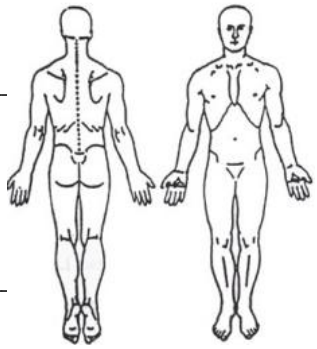
Confidential Health History Form

Name_____ Birthdate_____
Address_ _____ Email _____
City/State/Zip_____ Would you like to receive our newsletter? Y N
Phone (primary)_____ First time massage? Y N
Phone (additional)_____ Referred by_____

What is your primary need with your massage session today?

_____

<u>In the figure to the right, shade in the areas of your body that are painful, tense, or need attention during your massage.</u>



How did the above condition come about? When did it start?

_____

List any major surgeries and dates.

_____

List any recent injuries or accidents.

_____

Do you have any ongoing conditions that you deal with on a regular basis? If yes, please explain.

_____

List any medications you are taking.

_____

Please list any symptoms or conditions you may have in the following categories:

Head/Neck	
Spine	
Joint	
Muscular/Ligament	
Cancer	
Circulatory/Heart	
Respiratory	
Neurological	
Digestive	
Urinary	
Bone	
Immune	
Skin	
Reproductive	
Other	
Assistive Devices	

Please checkmark the following sensitivities that apply to you.
Heat____ Cold____ Light____ Noise____ Odor____ Ticklish____ Easily Bruised____ Closed Spaces____

Please list any likes concerning massage or preferences to any area of the body that gets massaged.

_____

Please list any dislikes concerning massage or sensitivities to any area of the body that gets massaged.

_____

What questions do you have about massage or this massage session?

_____