

Medical History

Please indicate any existing or recent conditions:

- | | | |
|---|---|--|
| <input type="checkbox"/> AIDS/HIV+ | <input type="checkbox"/> Fibromyalgia | <input type="checkbox"/> Pregnant (list below) |
| <input type="checkbox"/> Allergies (list below) | <input type="checkbox"/> Headaches/Migraines | <input type="checkbox"/> Rheumatoid arthritis |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Heart Problems | <input type="checkbox"/> Skin conditions |
| <input type="checkbox"/> Back problems | <input type="checkbox"/> High blood pressure | <input type="checkbox"/> Sprains/strains |
| <input type="checkbox"/> Blood disorders | <input type="checkbox"/> Insomnia | <input type="checkbox"/> Spinal problems |
| <input type="checkbox"/> Broken bones/pins | <input type="checkbox"/> Low blood pressure | <input type="checkbox"/> Strokes |
| <input type="checkbox"/> Cancer | <input type="checkbox"/> Muscle spasms/cramps | <input type="checkbox"/> Surgeries |
| <input type="checkbox"/> Carpal Tunnel | <input type="checkbox"/> Neck Problems | <input type="checkbox"/> TMJ/jaw pain |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Numbness | <input type="checkbox"/> Other |
| <input type="checkbox"/> Disc problems (list below) | <input type="checkbox"/> Osteoarthritis | |

Please explain every checked condition: _____

Please list current medications: _____

Have you ever received professional massage therapy? Yes No

If yes, when was your last massage? _____

Desired pressure: Light Firm Deep

Any Concerns? _____