## Current Health

Are you currently under a physician's care for an acute or chronic illness? [ ] Yes [ ] No

If yes, please explain ______________________________________________

______________________________________________

Are you currently taking any medication or dietary supplements? [ ] Yes [ ] No

[ ] Blood Pressure [ ] Aspirin/Anti-inflammatory [ ] Muscle Relaxers [ ] Pain Killers

[ ] Blood Thinners [ ] Anti-Anxiety/Depressants [ ] Sleeping Pills [ ] Cortisone Injections.

Other Medication or supplements:______________________________________________

Allergies/Hypersensitivity?______________________________________________

Are you allergic to any Creams, Lotions or Essential Oils [ ] Yes [ ] No

If yes, please explain:______________________________________________

Are you pregnant? [ ] Yes [ ] No

Do you experience difficulty laying on your stomach, back, or any other parts of your body?

[ ] Yes [ ] No

Did a health care practitioner refer you for massage therapy [ ] Yes [ ] No

Date of last massage? ______________

What results do you want from your massage session? ______________________________

______________________________________________

Where do you feel pain or tension?______________________________________________

Do you have limited range of motion? If so, where?______________________________

Any other medical conditions your massage therapist should know about? ______________

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