

# *Metta Massage Therapy*

## Medical History Form (Page 1 of 2)

|                             |                               |                     |
|-----------------------------|-------------------------------|---------------------|
| Name                        | Date of birth                 | Today's date (v3.4) |
| Address                     | Employer                      | Home phone          |
| City/State/Zip              | E-mail address                | Work phone          |
| Emergency contact and phone | Who referred you for massage? | Cell Phone          |

### Health Care Information

|                                |                    |                                |                    |
|--------------------------------|--------------------|--------------------------------|--------------------|
| Primary health care provider   |                    | Other provider and modality    |                    |
| Address                        |                    | Address                        |                    |
| Telephone                      | Date of last visit | Telephone                      | Date of last visit |
| Current diagnosis or treatment |                    | Current diagnosis or treatment |                    |

May I consult confidentially with your health care provider(s) if it would be helpful? **Please initial:** Yes \_\_\_\_\_ No \_\_\_\_\_

**Current Medications** (prescription, over-the-counter, and herbal ) Please include dosage & frequency if known:

|  |  |
|--|--|
|  |  |
|  |  |
|  |  |

**Personal Medical History** Please **(CIRCLE)** conditions experienced within the last 12 months and **UNDERLINE** older conditions.

**Skeletal** broken/fractured bone bursitis arthritis tendonitis osteoporosis joint/bone pain other

**Muscular** sprain/strain spasm/cramp headache neck/shoulder/arm pain low back/hip/leg pain jaw pain/TMJ other

**Circulatory** heart condition high/low blood pressure varicose veins blood clots edema lymphedema phlebitis other

**Digestive** constipation diarrhea gas/bloating diverticulitis irritable bowel syndrome indigestion/reflux ulcer other

**Nervous** numbness/tingling chronic pain herpes/shingles headache migraine fatigue sleep disorder carpal tunnel other

**Skin** allergy rash warts athletes foot plantar-wart difficult scaring other

**Reproductive** pregnancy #\_\_\_ PMS Breast: injury pain congestion/swelling internal scarring fibrocystic other

**Respiratory** breathing difficulty sinus problems allergies asthma other

**Other** chemical sensitivity contagious disease anxiety depression diabetes drug/alcohol eating disorder food sensitivity

aids hiv positive nicotine/caffeine implant/prosthesis contact lens pacemaker

**Additional Page(s) Attached** Cancer Headache Fibromyalgia Multiple Sclerosis Parkinson's Breast Other \_\_\_\_\_

*May you be at peace. May your heart remain open. May you awaken to the light of your own true nature.  
May you be healed. May you be a source of healing to all beings ..... The metta of the Buddha*

# Metta Massage Therapy

Name \_\_\_\_\_ | **Medical History (Page 2 of 2)** | Today's date \_\_\_\_\_ (v3.4)

**Surgeries (except cancer related), significant accidents or major injuries:** Please describe: \_\_\_\_\_ Year \_\_\_\_\_

## Lifestyle

|                                |                                 |                          |                              |
|--------------------------------|---------------------------------|--------------------------|------------------------------|
| Single or Partner?             | Does anyone else live with you? | Ages of children?        | Do you have pets?            |
| Physical activities at work?   | Do you exercise? How often?     | What do you do to relax? | Do you sleep well? Position? |
| Do you smoke? (amount per day) | Alcohol? (amount per week)      | Height                   | Weight                       |

## Touch History

Have you experienced emotional, physical or sexual abuse? \_\_\_\_\_

Are there areas of your body that are touch sensitive? \_\_\_\_\_ If so, in what way? \_\_\_\_\_

A female breast may be treated to facilitate recovery from surgery or radiation, to improve scars, to relieve general discomforts, or for a more complete massage experience. The nipple and areola are not touched. Please indicate which, if any, you are interesting in learning more about: \_\_\_Surgical or radiation recovery \_\_\_Scars \_\_\_General discomforts \_\_\_Complete experience

The pubic area, genitals and the gluteal cleft are not uncovered or touched.

Are there any other areas you do not want massaged? \_\_\_\_\_

Approximately how many massages have you had? \_\_\_\_\_ How long since your last massage? \_\_\_\_\_

What did you like best about them? \_\_\_\_\_ Least? \_\_\_\_\_

What are your reasons for receiving massage now? \_\_\_\_\_ Are you allergic to any lotions or oils? \_\_\_\_\_

## Consent

It is my choice to receive massage therapy. I recognize that treatment is given for the wellbeing of body and mind. This includes stress reduction; relief from muscular tension, spasm and pain; increased circulation and energy flow. I understand that I can stop or modify the treatment at any time and agree to communicate with my therapist immediately should I feel my wellbeing is being compromised.

I, \_\_\_\_\_, understand that massage therapists do not diagnose illness, disease, or any mental or physical disorder; do not prescribe medical treatment or pharmaceuticals; and do not perform spinal thrust manipulations. I acknowledge that massage is not a substitute for medical examination or diagnosis and that I must see a physician for those services.

If I have cancer or a chronic disease, I have previously consulted with my physician about massage and I have informed my massage therapist of any suggested limitations and restrictions.

I have stated all medical conditions of which I am aware, including communicable disease, and I will promptly inform my massage therapist of any change in my health status.

Signature \_\_\_\_\_ Date \_\_\_\_\_

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