Oasis Massage
Health History

Client Name: _____ DOB:_____

Please indicate conditions that you have or have had in the past. Describe any treatment received.

❒ Ongoing ❒ Past Muscle or joint pain: _____

❒ Ongoing ❒ Past Muscle or joint stiffness: _____

❒ Ongoing ❒ Past Numbness or tingling: _____

❒ Ongoing ❒ Past Swelling: _____

❒ Ongoing ❒ Past Bruise easily: _____

❒ Ongoing ❒ Past Sensitive to touch/pressure: _____

❒ Ongoing ❒ Past High/Low blood pressure: _____

❒ Ongoing ❒ Past Stroke or Heart attack: _____

❒ Ongoing ❒ Past Varicose veins: _____

❒ Ongoing ❒ Past Shortness of breath/Asthma: _____

❒ Ongoing ❒ Past Cancer: _____

❒ Ongoing ❒ Past Neurological (MS/Parkinson's/chronic pain): _____

❒ Ongoing ❒ Past Epilepsy or Seizures: _____

❒ Ongoing ❒ Past Headaches or Migraines: _____

❒ Ongoing ❒ Past Dizziness or Ringing in the ears: _____

❒ Ongoing ❒ Past Digestive conditions (Crohn's/IBS): _____

❒ Ongoing ❒ Past Gas, Bloating or Constipation: _____

❒ Ongoing ❒ Past Kidney disease/infection: _____

❒ Ongoing ❒ Past Arthritis (rheumatoid/osteoarthritis): _____

❒ Ongoing ❒ Past Osteoporosis or Degenerative spine/disk: _____

❒ Ongoing ❒ Past Scoliosis: _____

❒ Ongoing ❒ Past Broken bones: _____

❒ Ongoing ❒ Past Allergies: _____

❒ Ongoing ❒ Past Diabetes: _____

❒ Ongoing ❒ Past Endocrine or Thyroid conditions: _____

❒ Ongoing ❒ Past Depression or Anxiety: _____

❒ Ongoing ❒ Past Memory Loss, Confusion or Easily overwhelmed: _____

Additional Comments: _____

_____

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Client Name: _____ DOB:_____

Are you wearing: ☐ contacts? ☐ dentures? ☐ a hairpiece? ☐ other prosthetic? _____

Are you pregnant? ☐ Yes ☐ No *If yes, please complete Pregnancy Intake.*

Are you taking any medications? ☐ Yes ☐ No *If yes, please list them below.*

Medication	*Dosage*	*Side Effects, if any*

Do you currently have any of the following:

Blood clots	☐ Yes ☐ No	Infections	☐ Yes ☐ No
Congestive heart failure	☐ Yes ☐ No	Contagious diseases	☐ Yes ☐ No
Pitted edema	☐ Yes ☐ No		

Please answer honestly; some services may not be medically appropriate for the above conditions.

Informed Consent

Because massage/bodywork should not be performed under certain medical conditions, I affirm that I have stated all my known medical conditions and answered all questions honestly. I agree to keep the practitioner updated as to any changes in my medical profile and understand that there shall be no liability on the practitioner's part should I fail to do so. I understand that all information that I provide will be kept confidential unless otherwise required by law. I understand and consent that my medical information may be shared with other massage therapists employed here.

Client Signature: _____Date: _____

I have reviewed this Health History and updated any missing or incorrect information.

Client Signature: _____ Date: _____

Client Signature: _____ Date: _____

Client Signature: _____ Date: _____

Client Signature: _____ Date: _____