Confidential Medical History ~ Fraser Massage & Myofascial Release
www.FraserMassageMFR.com

Name_____ **Address**_____

Date of Birth_____ **Who referred you for treatment** _____

Home phone _____**Cell** _____

Email _____

Work phone _____**Occupation:** _____

Health History

Primary health concerns/goals:

_____

Are you currently under the care of a medical Doctor or licensed health care professional **for any above concerns**?

If yes, physicians name and contact #: _____

How long/ when did the concerns become an issue _____

Secondary Health Concerns:

_____

Are you currently taking *any* **pain medications or blood thinners**?

(If so, please list)

_____

Do you have **allergic reactions** to any substances? (**Allergies include peanuts, almonds or oils**)

If yes, please list _____

History of trauma (physical or emotional), accidents and/or surgery:

_____

_____

Therapeutic Goals: _____

_____

_____

Please circle any of the conditions you have had in the past or currently have:

Cardiovascular Disease	Numbness/tingling	Kidney Disease
Diabetes	Neck or back pain	Varicose Veins
Anxiety/Depression	HIV/AIDS	Menstrual Issues
Digestive Problems	Sinus Problems	Migraine or headaches
Chronic Fatigue Syndrome	Blood clots	Constipation/Irritable Bowel
TMJ Dysfunction/Jaw Pain	Muscle/Joint Pain	Arthritis

I understand that Myofascial Release/Massage Therapy may be contraindicated. A referral from a primary care physician may be required. I further understand that bodywork should not be a substitute for medical examination, diagnosis or treatment, and I should see a physician, chiropractor or other qualified medical specialist for any mental or physical ailments that are beyond the scope of practice for my massage therapist. I understand the therapist neither diagnoses illness, disease or medical disorders, nor performs spinal manipulations. I am responsible for consulting a qualified physician for any ailment that I have. I understand that failure to disclose medical conditions, for which MFR or massage is contraindicated, could result in injury or exacerbation of symptoms for which the therapist will not be held legally responsible. I understand that I will be charged full price for appointments cancelled without a 24-hour notice. I will update my therapist with any changes to my medical history. It is my understanding that any illicit or sexually suggestive remarks or advances made by me will result in immediate termination of the session, and I will be liable for the full payment of the scheduled appointment. By signing below, I agree to the above statements.

Client's Signature: _____Date: _____

Client’s printed name _____