Living Zing Massage

Medical History Form

Last Name: _____ First Name: _____ DOB: / /

Email: _____ Phone: _____

Address: _____

Occupation current and/or previous: _____

Reason for today's visit: _____

Do you have difficulty lying flat (horizonal)? ☐ Yes ☐ No

If yes, please explain: _____

Do you have any allergies? ☐ Yes ☐ No If yes, please list: _____

Do you have a pacemaker or implanted defibrillator: ☐ Yes ☐ No

Do you smoke? ☐ Yes ☐ No Do you drink alcohol? ☐ Yes ☐ No How much? _____

List all medications and topicals that you use regularly, including prescriptions, over the counter meds, vitamins and herbal supplements: _____

_____

If female, are you pregnant or nursing? ☐ Yes ☐ No

Do you have or have you ever had the following diseases or conditions? (Yes or No)

Skin cancer	Y	N	If yes, details:
Specific skin conditions	Y	N	If yes, details:
Cold sores	Y	N	If yes, details:

Do you have any of these health conditions? (Circle 'Y' for Yes or 'N' for No)

Osteoporosis	Y	N	Angina	Y	N	Kidney disease	Y	N
Arthritis	Y	N	High blood pressure	Y	N	Cancer	Y	N
Artificial joints	Y	N	High Cholesterol	Y	N	Epilepsy/seizure	Y	N
Varicose veins	Y	N	Heart murmur	Y	N	Migraines / headaches	Y	N
Vertigo/ Dizziness	Y	N	Emphysema	Y	N	Alzheimer's / dementia	Y	N
Oedema/ swelling	Y	N	Asthma/ wheezing	Y	N	Diabetes	Y	N
Artificial heart valve	Y	N	Stroke	Y	N	Gastrointestinal disease	Y	N
Peripheral vascular disease	Y	N	Thyroid disease	Y	N	Liver disease / hepatitis	Y	N
Congestive heart failure	Y	N	Seasonal allergies	Y	N	Depression / anxiety	Y	N
History of heart attack	Y	N	Bleeding/ clotting disorder	Y	N	Physical disability	Y	N

List any other conditions/ major surgeries: _____

_____

Completed by: ☐ patient ☐ family member (Read and reviewed with the patient)

Patient signature: _____ Date: / /