Health History Form

The information requested below will assist us in treating you safely. Feel free to ask any questions about the information being requested. Please note that all information provided below I'll be kept confidentially unless allowed or required by law. Your written permission will be required to release any information.

Name: _____ Phone # _____

Address: _____ Email: _____

Occupation: _____ Date of Birth: _____

Have you received massage therapy before: ☐ Yes ☐ No

Did a health care practitioner refer you for massage therapy? ☐ Yes ☐ No

If yes, please provide their name and address: _____

Please check any conditions you are experiencing or have experienced:

Cardiovascular

- ☐ High blood pressure
- ☐ Low blood pressure
- ☐ Chronic congestive heart failure
- ☐ Heart Attack
- ☐ Phlebitis/varicose veins
- ☐ Stroke/CVA
- ☐ Pacemaker or similar devices
- ☐ Heart disease

Is there family history of any of the above?
☐ Yes ☐ No

Respiratory

- ☐ Chronic cough
- ☐ Shortness of breath
- ☐ Bronchitis
- ☐ Asthma
- ☐ Emphysema

Is there family history of any of the above?
☐ Yes ☐ No

Infections

- ☐ Hepatitis
- ☐ Skin Conditions
- ☐ TB
- ☐ HIV
- ☐ Herpes

Other Conditions

- ☐ Loss of sensation, where?
- ☐ Diabetes, onset: _____
- ☐ Allergies/hypersensitivity to what? _____
- ☐ Type of reaction: _____
- ☐ Epilepsy
- ☐ Cancer, where?
- ☐ Skin conditions, what?
- ☐ Arthritis

Is there a family history of arthritis?
☐ Yes ☐ No

Head/Neck

- ☐ History of headaches
- ☐ History of migraines
- ☐ Vision problems
- ☐ Vision loss
- ☐ Ear problems
- ☐ Hearing loss

Women

Pregnant, due: _____

Gynaecological conditions?
_____

Overall, how is your genera health?
_____

Primary Care Physician:
_____

Address:_____

Current Medications: _____

Condition it treats: _____

Are you currently receiving treatment from another health care profession?
☐ Yes ☐ No

If yes for what? _____

Surgery – date _____

Nature: _____

Injury – date _____

Nature: _____

Nature: _____

Do you have any other medical conditions: (e.g., Digestive conditions, haemophilia, osteoporosis, mental illness) ☐ Yes ☐ No

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Do you have any internal pins, wires, artificial joints or special equipment?
☐ Yes ☐ No

Do you have any internal pins, wires, artificial joints or special equipment?
☐ Yes ☐ No

What? _____

Where? _____

What type of massage would you prefer?

- ☐ Treatment focused – I'm dealing with pain/injury
- ☐ Relaxation – I want this time to mellow out
- ☐ Little of both – I have some areas that hurt but I don't want the massage to be painful

How much pressure do you prefer? (please circle one)

1----------2----------3----------4----------5
Light Deep

Do you prefer talking during your treatment?

☐ No ☐ I want to talk about the treatment

☐ Sure, depends ☐ Yes

What is the reason you are seeking massage therapy? Please include the location of any tissue or joint discomfort.

I understand that it is my responsibility to tell my therapist I want more or less pressure.

I understand that id I do not cancel within 24 hours of my appointment time or fail to show up to my appointment, I will be charged half of my appointment fee.

Signature: _____

Date: _____

Date of Initial Health History: _____
Update 1 _____
Update 2 _____
Update 3 _____
Update 4 _____