Health History Form

The information request 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 will be kept confidentially unless allowed or required by law. Your written permission will be required to release any information.

Name: _____ Date of Birth: _____

Address: _____ City: _____ Postal Code: _____

Phone #: _____ Email: _____

Occupation: _____

Emergency Contact: _____ Phone #: _____ Relationship: _____

Primary Care Physician: _____ Address: _____

In General, how is your health? _____

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

_____

Do you have any other medical conditions? (e.g. digestive conditions, maemophilia, osteoporosis, mental illness) Yes No

If yes, what? _____

Current Medications: _____

Conditions it/they treat(s): _____

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

If yes, what? _____

Previous injuries (incl. dates): _____

Previous surgeries (incl. dates): _____

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

If yes, what and where? _____

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 indicate 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
pace maker or similar device
heart disease

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

Respiratory

chronic cough
shortness of breath
bronchitis
asthma
emphysema

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

Infections

hepatitis
skin conditions
TB
HIV
herpes

Head/Neck

history of headaches
history of migraines
vision problems
vision loss
ear problems
hearing loss

Women

pregnant, due: _____
gynecological conditions
what? _____
_____
_____
_____

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 any of the above? Yes No

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