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: _____ Phone # _____
Address:_____ City: Postal Code:
Occupation:_____ Date of Birth: _____
Have you received massage therapy before? Yes No Email: _____
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:

In General, how is your health?

_____

Primary Care Physician:

_____

Address:

_____

_____

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

Head/Neck

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

Women

pregnant, due: _____
gynecological conditions
what? _____
_____

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 any of the above? Yes No

Current Medications:

_____
condition it treats: _____
_____

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

If yes, for what? _____
_____

Surgery – date _____
nature: _____

Injury – date _____
nature: _____

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

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

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

_____
_____
_____

Notes:

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