Massage Therapy 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 confidential unless allowed or required by law. Your written permission will be required to release any information.

Name:____________________________ Occupation:________________________

Phone #:_________________________ Date of Birth:_______________________

Address:__________________________

Please indicate if you are experiencing or have experienced:

Cardiovascular

___ High blood pressure

___Low blood pressure

___Congestive heart failure

___Heart attack

___Phlebitis/ varicose veins

___CVA/ Stroke

___Pacemaker 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

Other Conditions

-Loss of sensation. Where?____________________

-Diabetes. Onset? ___________________________

-Allergies/hypersensitivity? _____________________

-Epilepsy? __________________________________

-Family history of arthritis?

__Yes __No

-Cancer. Where? _______________________

-Skin condition? ________________________

-Arthritis? Where?_______________________

Head/ Neck

__History of headaches

__History of migraines

__ Vision problems

__Vision loss

__Ear problems

__Hearing loss

Women

-Pregnant? Due date? _________________

-Gynaecological conditions? ___________________

General

Overall, how is your general health? ________________

Primary care physician? ___________________

Physician address :____

Current

Medications:____

____

Condition the medication treats:

____

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

If yes, for what?:

____

Have you ever had surgery? Yes No

If yes, please list area and date:

____

____

Are you waiting to have surgery? Yes No

Future surgery date? ________________________

Injury date: ________________________________

Do you have any other medical conditions? (e.g. digestive conditions, haemophilia, osteoporosis, arthritis)____

____

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 indicate the area of muscle or joint discomfort.

____

____

Notes:

Date of Initial Health History: _______________

Update 1_______________

Update 2_______________

Update 3_______________