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.

M / F D.O.B ________________ (DD/MM/YYYY)

Name: ____ Phone # ________________________

Address:____ City: ________________________

Postal Code:________________ Occupation: ____

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 **circle** 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 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 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, what?______________________

Overall, how is your general health? ______________________________

Primary Care Physician: __________________________

Address: __________________________

____

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.

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Patient Signature: ________________________________ Date: __________________

Please be advised that missed appointments will be charged 1/2 the fee of the appointment.

Notes:

Date of initial Health History:______________

Update 1 ____________

Update 2 ____________

Update 3 ____________

Update 4 ____________