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.

_____

_____

_____

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 _____