HEALTH HISTORY FORM

An accurate health history is important to ensure that it is safe for you to receive a massage treatment. All information gathered for this treatment is confidential except as required or allowed by law. Written authorization will be required for release of any information. **24-hour cancellation notice is required otherwise a missed appointment fee will be charged.**

First Name: ______________________ Last Name: ______________________

Address: ______________________ Ph (Home): ______________________

City: __________ Province: __________ Ph (Bus): ______________________

Postal Code: __________ Date of Birth: MM/DD/YY Ph (Cell): ______________________

Gender: ______ Occupation: __________ Email: ______________________

Recreational activities: ______________________ Emergency contact person: ______________________

Do you have a primary health care physician? ☐ Yes ☐ No Emergency contact phone: ______________________

Physicians name: ______________________ Primary Complaint: ______________________

Physicians address: ______________________ ______________________ How long? ______

Physicians phone: ______________________ General Health Status: ______________________

How did you hear about us? ______________________ Is this your 1st massage therapy treatment? ☐ Yes ☐ No

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HEALTH HISTORY: Please indicate conditions you are experiencing, present or past.

☐ Smoker

ACCIDENT/INJURY

☐ Car Accident

☐ Work-related Date: MM/DD/YY

Symptoms: ______________________

____

____

CARDIOVASCULAR

☐ High/low blood pressure

☐ Heart attack | Date: MM/DD/YY

☐ Phlebitis/DVT

☐ Stroke/CVA | Date: MM/DD/YY

☐ Pulmonary emboli

☐ Pacemaker

☐ Heart disease

☐ Angina

☐ Varicose veins

☐ Chronic congestive heart failure

☐ Family history of any of the above

GASTROINTESTINAL

☐ Irritable bowel syndrome

☐ Colitis

☐ Gastroenteritis

☐ Crohn's disease

☐ Constipation/Bloating

HEADACHES HISTORY

☐ Tension ☐ Migraines

☐ Tooth/Jaw/Ear pain

☐ Head trauma | date: __________

☐ History of headaches | type: ______

____

☐ Other: ______________________

INFECTIOUS DISEASE

☐ Hepatitis

☐ Infections/skinconditions

☐ Tuberculosis

☐ HIV

☐ Other: ______________________

SOFT TISSUE/JOINTS & BONES

Specify its nature: pain, stiffness, numbness, twitching etc.

	Present	Past
☐ Neck	________	________
☐ Shoulder	________	________
☐ Upper Back	________	________
☐ Mid Back	________	________
☐ Low Back	________	________
☐ Arms	________	________
☐ Chest	________	________
☐ Legs	________	________
☐ Knees	________	________
☐ Hips Other	________	________
☐ Fractures	________	________
☐ Arthritis	________	________

SKIN

☐ Skin condition | type: __________

☐ Bruise easily

☐ Athletes foot

☐ Loss of sensation

REPRODUCTIVE

- [ ] Pregnant | due date: MM/DD/YY
- [ ] Gynecological condition(s): ______

______
______
______

RESPIRATORY

- [ ] Chronic cough
- [ ] Shortness of breath
- [ ] Bronchitis
- [ ] Asthma
- [ ] Emphysema
- [ ] Pneumonia
- [ ] Sinus problems

- [ ] Pins/wires/prosthetics

- [ ] Medic alert bracelet | specify condition or allergy ______

______
______

OTHER CONDITIONS

- [ ] Neurological conditions
- [ ] Epilepsy
- [ ] Diabetes | onset: ______
- [ ] Allergies | type: ______
- [ ] Cancer | type: ______
- [ ] Family history of arthritis
- [ ] Vision loss
- [ ] Hearing loss
- [ ] Insomnia
- [ ] Haemophilia
- [ ] Kidney/Bladder problems
- [ ] Dialysis
- [ ] Overactive bladder
- [ ] Osteopenia
- [ ] Osteoporosis
- [ ] Positional vertigo
- [ ] Mental health disorder
- [ ] Other: ______

Stress level 1 - 10: ______

SURGERY

Type: ______

Date: MM/DD/YY Current symptoms: ______

______
______

- [ ] Present involvement in other health care. If yes, specify: ______

______
______
______

CURRENT MEDICATIONS & CONDITIONS

______
______
______
______

HEALTH HISTORY CONSENT

I acknowledge and understand that the massage therapist must be fully aware of my existing medical conditions. I have completed my medical history form as provided and disclosed to the massage therapist all my medical conditions. I understand that it is my responsibility to keep the massage therapist updated on my medical history. The information provided is true and complete to the best of my knowledge. I consent to be assessed by my massage therapist, using a variety of examinations and techniques, for the conditions noted in my health history. I have read the above consent and I have had an opportunity to ask questions about my massage therapy assessment. I understand that I may withdraw my consent to assessment at any time and that the assessment will be stopped. By signing this form, I confirm my consent to assessment and intend this consent to cover the assessment discussed. I understand that all information gathered is confidential and that I must give consent for my health records to be released.

Patient Name (Please print): ______ Date: MM/DD/YY

Patient Signature (or signature of parent/guardian) ______