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:

Occupation: Date of birth:

Have you received massage therapy before Yes ☐ No ☐

Did a health care provider refer you for massage therapy? Yes ☐ No ☐

If yes, please provide the name

Reason you're seeking massage therapy (please indicate the area of any joint or tissue discomfort) :

Please indicate below 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 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

Infections

- ☐ hepatitis
- ☐ skin condition
- ☐ TB
- ☐ HIV
- ☐ herpes

Other conditions

Loss of sensation, where?

Diabetis, onset:

allergies/hypersensitivity, to what?

type of reaction:

- ☐ epilepsy

cancer, where?

Skin conditions,what?

- ☐ arthritis

Is there a family history of arthritis?

Yes ◯ No ◯

Women

pregnant, due:

Gynecological conditions, what?

Overall, how is your general health?

Primary care physician:

Do you have any other medical conditions (E.g digestive conditions, hemophilia,oesteoporosis, mental illness) Yes ◯ No ◯

What?:

Do you have any internal pins, wires or artificial joints/special equiptment?

What?

Where?

Medication:

Condition it treats: