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. **A 24hr cancellation notice is required, otherwise a missed appointment fee will be charged.**

Name: _____ Tel. Bus: _____ Tel. Res. _____
Address: _____ City: _____ Postal Code: _____
Date of Birth: _____ Occupation: _____
(MM/DD/YYYY)
Have you received massage therapy before? YES/N0
Did a health care practitioner refer you for massage therapy? YES ☐/NO ☐If yes, please provide their name and address:
_____
Primary Care Physician _____ Tel No: _____ Address: _____
*** What is the Reason for Massage Treatment?** _____

Please indicate ☑ conditions you are experiencing or experienced:

Cardiovascular
☐High blood pressure
☐Low blood pressure
☐Chronic congestive heart failure
☐Heart attack
☐phlebitis/ varicose veins
☐Stroke/ CVA
☐Pacemaker or similar devices
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?
_____
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: _____
☐Gynecological Conditions, what?
_____

Overall how is your general Health?
_____
_____
_____
_____

Current Medications:
_____
Condition it treat; _____

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? _____

I have read the above information and have stated all my previous and current medical conditions. I take it upon myself to update the massage therapist regarding any changes in my condition. I understand that all massage treatments will be discussed and planned with the massage therapist, and will require informed consent.

Signature: _____ **Date:** _____

Update 1 _____
Update 2 _____
Update 3 _____
Update 4 _____