MASSAGE PATIENT HEALTH HISTORY FORM

For your information: Date: ____________

An accurate health history is important to ensure that it is safe for you to receive a massage treatment. If your health status changes in the future, please let me know. All inforation gathered for this treatment is confidential except as required by law or except to facilitate diagnosis (assessment) or treatment. You will be asked to provide written authorization for release of any information.

Name: ____________ Date of Birth: ____________

Address: ____________ City/Town: ____________

Province: ____________ Postal Code: ____________

Home Phone: ____________ Cell Phone: ____________

Email: ____________ May we email you? YES ☐ NO ☐ Text? YES ☐ NO ☐

Occupation: ____________ Date of last massage:: ____________

Referred by: ____________ Gender: Female ☐ Male ☐ Other ☐

Please indicate conditions you are experiencing or have experienced:

Respiratory

- ☐ chronic cough
- ☐ shortness of breath
- ☐ bronchitis
- ☐ asthma
- ☐ emphysema

Is there a family history of any of the above? YES ☐ NO ☐

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 ☐

Women

- ☐ pregnant, due ____________
- ☐ gynacological conditions, what? ____________

Infections

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

Other Conditions

- ☐ loss of sensation, where? ____________
- ☐ diabetes, onset: ____________
- ☐ Allergies/hypersensitivities to what? ____________ reaction: ____________
- ☐ epilepsy
- ☐ cancer, type? ____________
- ☐ skin condition, what? ____________
- ☐ fibromyalgia
- ☐ arthritis

Is there a family history of arthritis? YES ☐ NO ☐

Do you smoke? YES ☐ NO ☐

Head/Neck

- ☐ history of headaches
- ☐ history of migraines
- ☐ vision problems
- ☐ vision loss
- ☐ ear problems
- ☐ hearing loss

Soft Tissue/Joint Discomfort and it's nature:

- ☐ neck: ____________
- ☐ low back: ____________
- ☐ mid back: ____________
- ☐ upper back: ____________
- ☐ shoulders: ____________
- ☐ arms: ____________
- ☐ legs: ____________
- ☐ knees: ____________
- ☐ other: ____________

Primary Care Physician ____________

Address: ____________

Current Medications: ____________

Condition it treats: ____________

Surgery type: ____________
Date: ____________

Injury type: ____________
Date: ____________

Other Medical Conditions: ____________

Present involvement in other health care: YES ☐ NO ☐
If yes, please specify: ____________

Do you have any internal pins, wires, artificial joints or special equipment? ____________ YES ☐ NO ☐

Signature: ____________