HEALTH HISTORY FORM

This 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 confidential unless allowed or required by law. Your written permission will be required to release any information.

Name:_____ Phone # (home):_____ (Work):_____
Address:_____ City: _____ P.C.: _____
Occupation:_____ Date of birth:_____
E-mail address:_____

Have you ever received massage therapy before? ○ Yes ○ No
Did a health care professional refer you for massage therapy? ○ Yes ○ No
If yes, please provide their name and address:_____
_____

Cardiovascular	Infections	Head/Neck
○ 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 <u>Respiratory:</u> ○ Chronic cough ○ Shortness of breath ○ Bronchitis ○ Asthma ○ Emphysema	○ Hepatitis ○ Skin conditions ○ TB ○ HIV ○ Herpes <u>Other Conditions:</u> Loss of sensation, where? _____ Diabetes; onset: _____ Allergies / Hypersensitivity to what? _____ <u>Type of reaction:</u> _____ ○ Epilepsy ○ Cancer, where? _____ Skin Condition, What? _____ <u>Arthritis:</u> Is there a family history of arthritis? ○ Yes ○ No	○ History of headaches ○ History of migraines ○ Vision problems ○ Vision loss ○ Ear problems ○ Hearing loss _____ <u>Women:</u> ○ Pregnant; due: _____ ○ Gynecological condition, what? _____ Overall, how is you general health? _____ _____ <u>Primary Care Physician:</u> _____ Address: _____ _____ _____

Current Medications:

Are you currently receiving treatment from another health professional?
○ Yes ○ No
If yes, what?_____
_____

Surgery Date:_____
Nature:_____

Injury Date: _____
Nature:_____

Do you have any other medical conditions? E.g. (digestive conditions, haemophilia, osteoporosis, mental illness) ○ Yes ○ No

Do you have any internal pins, wires, artificial joints or special equipments? ○ Yes ○ No
What?_____
Where?_____

What is the reason you are seeking massage therapy?
_____
_____

Please indicate the location of any tissue or joint discomfort:_____
_____

*For office use only
Date of initial health:
History:_____ Update 1:_____ Update 2: _____ Update 3:_____ Update 4:_____