

Health History Form

The information request below will assist me in treating you safely. Ask any questions about the information being requested. All information provided below will be kept confidentially unless allowed or required by law. Your written permission is required to release any information.

Name: _____	phone #: _____
Address: _____	E-mail: _____
Occupation: _____	Date of Birth: _____
Have you received massage therapy before? <input type="checkbox"/> yes <input type="checkbox"/> no comments _____	
Did a health care practitioner refer you for massage therapy <input type="checkbox"/> yes <input type="checkbox"/> no comments _____	
If yes, provide their name & address _____	

Please indicate conditions you are experiencing or have experienced:

<p><u>Cardiovascular</u></p> <p><input type="checkbox"/> high blood pressure</p> <p><input type="checkbox"/> low blood pressure</p> <p><input type="checkbox"/> chronic congestive heart failure</p> <p><input type="checkbox"/> heart attack</p> <p><input type="checkbox"/> phlebitis/varicose veins</p> <p><input type="checkbox"/> stroke/CVA</p> <p><input type="checkbox"/> pace make or similar device</p> <p><input type="checkbox"/> heart disease</p> <p>*****</p> <p><u>Respiratory</u></p> <p><input type="checkbox"/> chronic cough</p> <p><input type="checkbox"/> shortness of breath</p> <p><input type="checkbox"/> bronchitis</p> <p><input type="checkbox"/> asthma</p> <p><input type="checkbox"/> emphysema</p>	<p><u>Infections</u></p> <p><input type="checkbox"/> hepatitis</p> <p><input type="checkbox"/> skin conditions</p> <p><input type="checkbox"/> TB</p> <p><input type="checkbox"/> HIV</p> <p><input type="checkbox"/> herpes</p> <p>*****</p> <p><u>Other Conditions</u></p> <p><input type="checkbox"/> loss of sensation – where? _____</p> <p>_____</p> <p><input type="checkbox"/> diabetes – onset: _____</p> <p><input type="checkbox"/> allergies/hypersensitivity to _____</p> <p>_____</p> <p><input type="checkbox"/> skin conditions – what? _____</p> <p>_____</p> <p><input type="checkbox"/> arthritis</p> <p>Is there a family history? _____</p>	<p><u>Head/Neck</u></p> <p><input type="checkbox"/> history of headaches</p> <p><input type="checkbox"/> history of migraines</p> <p><input type="checkbox"/> vision problems</p> <p><input type="checkbox"/> vision loss</p> <p><input type="checkbox"/> ear problems</p> <p>*****</p> <p><u>Women</u></p> <p><input type="checkbox"/> Pregnant? Due _____</p> <p><input type="checkbox"/> Gynaecological conditions what? _____</p> <p>*****</p> <p><u>Men</u></p> <p>any urological conditions? what? _____</p>
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Is there a family history of any of the above? yes no

Overall, how is your general health? _____

Primary care physician (name & address): _____

<p>Name medications and the reason you take them _____</p> <p>_____</p> <p>Are you currently receiving treatment from another health care professional? <input type="checkbox"/> yes <input type="checkbox"/> no If yes, for what? _____</p> <p>_____</p>	<p>Do you have any other medical conditions? (e.g. digestive, mental, osteoporosis, haemophilia) <input type="checkbox"/> yes <input type="checkbox"/> no what? _____</p> <p>_____</p> <p>Surgery (date) _____ nature: _____</p> <p>Injury (date) _____ nature: _____</p>
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What is the reason you are seeking massage therapy (include the location of any discomfort - _____)

Notes:

<p>Date of initial Health History _____</p> <p>Update 1 _____</p> <p>Update 2 _____</p> <p>Update 3 _____</p> <p>Update 4 _____</p>
