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? □ yes □ no comments
Did a health care practitioner refer you for massage therapy □ yes □ no comments _____
If yes, provide their name & address _____

Please indicate 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
- □ pace make or similar device
- □ heart disease

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Respiratory
- □ chronic cough
- □ shortness of breath
- □ bronchitis
- □ asthma
- □ emphysema

Infections
- □ hepatitis
- □ skin conditions
- □ TB
- □ HIV
- □ herpes

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Other Conditions
- □ loss of sensation – where?_____ _____
- □ diabetes – onset: _____
- □ allergies/hypersensitivity to _____ _____
- □ skin conditions – what? _____
- □ arthritis

Is there a family history?

Head/Neck
- □ history of headaches
- □ history of migraines
- □ vision problems
- □ vision loss
- □ ear problems

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Women
- □ Pregnant? Due_____
- □ Gynaecological conditions

what? _____

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Men

any urological conditions?
what? _____

Is there a family history of any of the above? □ yes □ no

Overall, how is your general health?

Primary care physician **(name & address)**:

Name medications and the reason you take them _____
_____

Are you currently receiving treatment from another health care professional? □ yes □ no If yes, for what? _____
_____

Do you have any other medical conditions? (e.g. digestive, mental, osteoporosis, haemophilia) □ yes □ no what?_____
_____

Surgery (date) _____ nature:_____
Injury (date) _____ nature: _____

What is the reason you are seeking massage therapy (include the location of any discomfort - _____
_____

Notes:

Date of initial Health History _____
Update 1 _____
Update 2 _____
Update 3 _____
Update 4 _____

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