

Health History Form

The information requested 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 #: _____

Address: _____ Date of Birth (d/m/y): ____/____/____

City: _____ Occupation: _____

Postal Code: _____ Email: _____

Have you received massage therapy before? Yes No

How did you hear about us? _____

Please indicate conditions you are experiencing or have experienced:

Cardiovascular

- High blood pressure
- Low blood pressure
- Chronic congestive heart failure
- Heart Attack
- Phlebitis
- Stroke / CVA
- Pacemaker or similar device
- Heart Disease

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? _____
- Arthritis

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: _____
- Gynaecological conditions, what? _____

Overall, how is your general health? _____

Primary Care Physician _____

Address: _____

Current Medications: _____

Condition it treats: _____

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? _____

What is the reason you are seeking massage therapy?

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