



Date _____

HEALTH HISTORY FORM for MASSAGE THERAPY

For your information:

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 information gathered for this treatment is confidential except as required or allowed by law, or except to facilitate diagnosis (assessment) or treatment. You will be asked to provide written authorization for release of any information.

First Name: _____ Last Name: _____ Mr. ___ Mrs. ___ Ms. ___

Address: _____ Postal Code: _____

Phone: Home: _____ work: _____ x: _____ cell: _____

e-mail: _____ Occupation: _____ Date of Birth: _____

Primary Concern/Complaint? _____

Who may we thank for referring you? _____

Health History: Please indicate conditions you are experiencing, or have experienced in the past:

<p align="center">GENERAL</p> <ul style="list-style-type: none"> headaches/migranes dizziness fatigue fibromyalgia chronic fatigue syndrome seasonal allergies 	<p align="center">RESPIRATORY</p> <ul style="list-style-type: none"> chronic cough bronchitis emphysema asthma 	<p align="center">CARDIOVASCULAR</p> <ul style="list-style-type: none"> high/ low blood pressure phlebitis heart / disease / attack stroke / CVA pacemaker chronic congestive heart failure 	<p align="center">SKIN</p> <ul style="list-style-type: none"> sensitive bruise easily eczema varicose veins psoriasis infectious conditions:
<p align="center">HEAD/NECK</p> <ul style="list-style-type: none"> vision problems ear problems vertigo sinus <p>ALLERGIES (please list):</p>	<p align="center">WOMEN</p> <ul style="list-style-type: none"> menstrual problems menopausal problems pregnant (due _____) <p align="center">MEN</p> <ul style="list-style-type: none"> prostate cancer testicular cancer 	<p align="center">COMMUNICABLE DISEASES</p> <ul style="list-style-type: none"> TB Hepatitis HIV 	<p align="center">OTHER</p> <ul style="list-style-type: none"> cancer arthritis OA arthritis RA epilepsy hemophilia diabetes – onset _____
<p align="center">SOFT TISSUE/JOINT DISCOMFORT</p> <ul style="list-style-type: none"> neck _____ shoulders _____ upper back _____ lower back _____ arms _____ legs _____ other _____ <p>Special Note of any Pins, Wires, artificial joints:</p>		<p>Current Medications: _____ Condition being treated: _____</p> <p>_____</p> <p>Physician _____</p> <p>Surgery _____ Date _____</p> <p>Injury _____ Date _____</p> <p>Other Healthcare Treatment _____</p>	

I understand and agree that the following information on this form is accurate, current and will be confidential. I consent to massage therapy treatment and have discussed with the therapist the nature and purpose of therapeutic massage. I understand and am informed that, as in all healthcare, there are some risks to treatment which, if applicable, will be discussed before the treatment.

 Signature

 Date