



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