Health History Form

The information requested below will assist me 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.

Name: _____ Date of Birth: _____
Address: _____ City: _____ Postal Code: _____
E-mail: _____ Occupation: _____
Phone: Home# _____ Work# _____ Mobile# _____

Overall, how is your general health? _____ Have you received massage therapy before? ☐ Yes ☐ No

Primary Care Physician: _____ Address: _____ Phone #_____

Did a health care practitioner refer you for massage therapy? ☐ Yes ☐ No
If yes, please provide their name and address _____

Please indicate conditions <u>you</u> are experiencing or have experienced:

<u>Cardiovascular</u>
- ☐ high blood pressure
- ☐ low blood pressure
- ☐ chronic congestive heart failure
- ☐ heart attack
- ☐ phlebitis / varicose veins
- ☐ stroke/CVA
- ☐ pacemaker or similar device
- ☐ heart disease

Is there a family history of any of the above? ☐ Yes ☐ No

<u>Respiratory</u>
- ☐ chronic cough
- ☐ shortness of breath
- ☐ bronchitis
- ☐ asthma
- ☐ emphysema

Is there a family history of any of the above? ☐ Yes ☐ No

<u>Infections</u>
- ☐ hepatitis
- ☐ skin conditions
- ☐ TB
- ☐ HIV
- ☐ herpes

<u>Other Conditions</u>
- ☐ loss of sensation, where? _____
- ☐ diabetes, onset: _____
- ☐ allergies/hypersensitivity to what? _____ type of reaction: _____
- ☐ epilepsy
- ☐ cancer, where? _____
- ☐ skin conditions, what? _____
- ☐ arthritis, type?_____

Is there a family history of arthritis? ☐ Yes ☐ No

<u>Head/Neck</u>
- ☐ history of headaches
- ☐ history of migraines
- ☐ vision problems
- ☐ vision loss
- ☐ ear problems
- ☐ hearing loss

<u>Women</u>
- ☐ pregnant Due: _____
- ☐ gynaecological conditions details?_____ _____

Do you have any other medical conditions?
(e.g. digestive conditions, haemophilia, osteoporosis, mental illness)
☐ Yes ☐ No
details? _____ _____ _____

Current **Medications** and **Conditions** treated:
_____
_____
_____

Surgeries – list dates and nature of the surgeries…
_____
_____
_____

Injuries – list dates and nature of the injuries…
_____
_____
_____

Are you currently receiving treatment from another health care professional? ☐ Yes ☐ No
If yes, for what? _____
_____

Do you have any internal pins, wires, artificial joints or special equipment? ☐ Yes ☐ No
Where? _____

What is the reason you are seeking massage therapy? Please include the location of any tissue or joint discomfort.
_____
_____
_____

MORE ↘

LIFESTYLE:

SLEEP: Hours/night? _____ Quality? _____ Rested on waking? _____

EATING HABITS: Is your diet adequate and balanced? _____

WATER: Amount/day? _____ COFFEE: Amount/day? _____

TEA: Amount/day? _____ ALCOHOL: Amount /week? _____

EXERCISE:	Type	Duration	Times/week
	_____	_____	_____
	_____	_____	_____
	_____	_____	_____

OTHER: Any other conditions, diseases, family history or stress factors not mentioned previously?

_____
_____
_____
_____

For Client's Use Please indicate areas of **pain** with '**X**'s and areas of **tightness** or **instability** with **parallel lines** '**//**'.