Massage Health History Form

The purpose of a health history form is to let us know about your current health status so that we know that a massage treatment is *safe* for you to receive. With an **accurate** health history**,** we can make an *effective* treatment plan specifically for you and, if necessary, modify the treatment to avoid any complications. If your health status changes in the future, please let us know in case we need to make changes to your treatment plan. All the information we gather from you is **strictly confidential.** The only time this information will be shared as if it is requested by law or to facilitate diagnosis or treatment however, your written consent will be asked for before the information is released.

First Name:_____ Last Name:_____

Date of Birth: _____ Gender: Male / Female (circle) Occupation:_____

What are you looking for today?

- ☐ Relaxation
- ☐ Pain Relief
- ☐ Other_____

Where is your primary complaint/Discomfort?

- ☐ Headache
- ☐ Upper Back
- ☐ Lower Back
- ☐ Neck
- ☐ Shoulders
- ☐ Hips
- ☐ Lower Leg
- ☐ Upper leg
- ☐ Arms
- ☐ Knees
- ☐ Hands
- ☐ Feet
- ☐ Other

For the following conditions, please check off the ones that apply to you now:

Respiratory

- ☐ Chronic cough
- ☐ Shortness of breath
- ☐ Bronchitis
- ☐ Asthma
- ☐ Emphysema

Cardiovascular

- ☐ High blood pressure
- ☐ Low blood pressure
- ☐ Congestive heart failure
- ☐ Heart attack
- ☐ Phlebitis
- ☐ Stroke
- ☐ Pacemaker or similar
- ☐ Heart disease

Skin Conditions

- ☐ Allergies/sensitivities
- ☐ Warts (type:_____)
- ☐ Bruise easily
- ☐ Fungal Infection (location:_____)

Infections

- ☐ Hepatitis (type:_____)
- ☐ Tuberculosis
- ☐ HIV/other STDs (type:_____)

Women

- ☐ Pregnant(due __/__/__ D M Y)
- ☐ Gynecological condition (type:_____)

Other Conditions

- ☐ Diabetes (type:_____) -onset__/__/__ D M Y
- ☐ Cancer_____
- ☐ Epilepsy
- ☐ Arthritis(Type): _____
- ☐ Vision loss/problem
- ☐ Hearing loss/problem

Current Medication:

_____

_____

_____

What it treats:

_____

_____

Are you also seeing another health care practitioner?

- ☐ Chiropractor
- ☐ Psychologist
- ☐ Physiotherapist
- ☐ Sports Therapist
- ☐ Other:_____

Other conditions not listed (previous injury/surgery, digestive, psychological, artificial joints, etc.): _____

_____

_____

Signature to consent to treatment:_____ Date:_____