Health History Form – MASSAGE THERAPY

WELCOME TO OUR OFFICE – An accurate health history is important to ensure that it is safe for you to receive massage treatment. If your health status changes in the future, please let us know

Name:		Date:
Address: Apt #:	City:	Postal Code:
Tel # (home)	Tel #: (cell)	Tel #: (work)
Date of Birth: (day/month/year) / /	Occupation:	
What is your primary complaint?		

Health History: Please indicate conditions you are experiencing or have experienced:

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

Cardiovascular
- ☐ High blood pressure
- ☐ Low blood pressure
- ☐ CCHF
- ☐ Heart attack
- ☐ Phlebitis
- ☐ Stroke/ CVA
- ☐ Pacemaker or similar device

Skin
- ☐ Skin conditions

Other Conditions
- ☐ Loss of sensation
- ☐ Diabetes (onset:_____)
- ☐ Allergies (e.g. anaphylaxis, or skin irritation)
- ☐ Epilepsy
- ☐ Cancer
- ☐ Arthritis

Head/ Neck
- ☐ Vision problems
- ☐ Vision loss
- ☐ Ear problems
- ☐ Hearing loss

Infections
- ☐ Hepatitis
- ☐ Skin conditions
- ☐ TB
- ☐ HIV

Women
- ☐ Pregnant (due:_____)

Soft Tissue/ Joint Discomfort
(and details of nature of pain)
- ☐ Neck_____
- ☐ Low back_____
- ☐ Mid back_____
- ☐ Upper back_____
- ☐ Shoulders_____
- ☐ Arms_____
- ☐ Legs_____
- ☐ Knee_____
- ☐ Other_____

What is your general health status: _____

Current Medications (and condition it treats):

Medical Doctor's Name (and tel #, clinic address):

Chiropractor's Name:

Previous Surgery (nature and date):

Previous injuries (nature and date):

Other Medical Conditions (e.g. digestive conditions, gynecological conditions, hemophilia etc):

Of Special Note (presence of internal pins, wires, artificial joints, special equipment):

Referred by: