Massage Therapy -Health History Form

The information requested below will assist us 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 confidentially unless allowed or required by law. Your written permission will be required to release any information.

Name: _____ Occupation: _____

Have you received massage therapy before? ☐ Yes ☐ No

Did a health care practitioner refer you for massage therapy? ☐ Yes ☐ No

If yes, please provide their name and address: _____

Please indicate conditions you are experiencing or have experienced:

CARDIOVASCULAR

- ☐ Low Blood pressure
- ☐ High Blood pressure
- ☐ Congestive Heart Failure
- ☐ Heart Attack
- ☐ Stroke /CVA
- ☐ Poor circulation
- ☐ Heart disease
- ☐ Pacemaker or similar disease
- ☐ Phlebitis/ Varicose Veins
- ☐ Pacemaker

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

RESPIRATORY

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

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

INFECTIONS

- ☐ TB
- ☐ HIV / AIDS
- ☐ Hepatitis
- ☐ Skin Conditions
- ☐ Herpes

WOMEN

- ☐ Pregnancy: Due date: _____
- ☐ Gynaecological conditions:

What: _____

HEAD AND NECK

- ☐ History of Headaches
- ☐ History of Migraines
- ☐ Vision problems
- ☐ Hearing loss
- ☐ Ear Problems

Overall, how is your general health?

_____

_____

OTHER CONDITIONS

- ☐ Osteoarthritis
- ☐ Rheumatoid Arthritis

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

- ☐ Epilepsy
- ☐ Diabetes, Onset: _____
- ☐ Loss of Sensation, where? _____
- ☐ Allergies/hypersensitivity to what: _____
- ☐ Cancer ☐ Yes ☐ No

Where? _____

Radiation/Chemotherapy in last 3 years ☐ Yes ☐ No

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

What? _____

_____

Current Medications: _____

_____ ☐ None

Previous / Current Treatment:

☐ Physiotherapy ☐ Massage Therapy ☐ Medical Doctor ☐ Chiropractic ☐ None

If yes, for what? _____

Previous / Current Surgeries (Nature and Dates): _____

_____

_____

Do you have any Internal Pins/Wires, Artificial Joints or Other special equipment ☐ Yes ☐ No

What and where? _____ ☐ None

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

_____

_____

Notes:

_____

_____

_____

Date of Initial Health History: _____

Update 1 _____

Update 2 _____

Update 3 _____

Update 4 _____