Health History Form

The information request below will assist 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:____ Email____
Home Phone _____________________ Work Phone______________________ Cell Phone_______________________

Address:____
Street City Province Postal Code
Occupation:____ _____________ Date of Birth:______________________

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

- ☐ high blood pressure
- ☐ low blood pressure
- ☐ chronic congestive heart
- ☐ 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

Respiratory

- ☐ chronic cough
- ☐ shortness of breath
- ☐ bronchitis
- ☐ asthma
- ☐ emphysema

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

Infections

- ☐ hepatitis
- ☐ skin conditions
- ☐ TB
- ☐ HIV
- ☐ herpes

Other Conditions

- ☐ loss of sensation, where? ______________________
- ☐ diabetes, onset:________
- ☐ allergies/hypersensitivity

to what?_____________________
type of reaction:________________

- ☐ epilepsy
- ☐ cancer, where? _____________________________
- ☐ skin conditions, what? _____________________________
- ☐ arthritis

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

Head/Neck

- ☐ history of headaches
- ☐ history of migraines
- ☐ vision problems
- ☐ vision loss
- ☐ ear problems
- ☐ hearing loss

Women

- ☐ pregnant, due:_________
- ☐ gynaecological conditions, what?________________________

Overall, how is your general health?
____

Primary Care Physician:
____

Address:
____
____

Current Medications:____________________________
____

Condition it treats:______________________________
____

Are you currently receiving treatment from another health care professional? ☐Yes ☐No

If yes, for what?_________________________________

Surgery — date_________________________________
nature: ____

Injury — date___________________________________
nature: ____

Do you have any other medical conditions? (ex. digestive conditions, haemophilia, osteoporosis, mental illness)
☐Yes ☐ No
what?____

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

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

Notes: