MASSAGE THERAPY

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| HEALTH HISTORY FORM  For you information:  An accurate health history is important to ensure that it is safe for you to receive a massage treatment. If your health status changes in the future, please let me know. All information gathered for this treatment is confidential except as required or allowed by law or except to facilitate diagnosis (assessment) or treatment. You will be asked to provide written authorization for release of any information.   |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  | | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | | |  |  | | --- | --- | | Name: |  |  |  |  | | --- | --- | | Address: | M | |  |  |  |  |  |  |  | | --- | --- | --- | --- | | Date of birth: |  | Occupation: |  | |  |  |  |  | | |  |  | | --- | --- | | Date: |  | | Tel: res |  | | bus |  | | Fax/email |  |  |  |  | | --- | --- | | What is your primary complaint? |  | | | |  |  |  |  | | --- | --- | --- | --- | | Who referred you? |  | Their Address? |  | |  |  |  |  | | | |

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| Health History Please indicate conditions you are experiencing, or have experienced: | | |
| **Respiratory**  chronic cough  shortness of breath  bronchitis  asthma  emphysema  **Cardio vascular**  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 (i.e. anaphylaxis)  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 its nature  neck  low back  mid back  upper back  shoulders  arms  legs  knees  other |
| |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  | | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | | |  |  | | --- | --- | | Current Medications: |  | | Condition it treats: |  |  |  |  |  |  | | --- | --- | --- | --- | | Surgery: |  | date: |  | | nature: |  | | |  |  |  |  |  | | --- | --- | --- | --- | | Injury: |  | date: |  | | nature: |  | | | |  |  | | | | |  |  |  | | --- | --- | --- | | Primary Care Ph ysician: | |  | | Address: |  | |  |  |  | | --- | --- | | Present Involvement in Other Health care: YesNo | | | If yes, please specify: |  | |  | | |  | | |  |  |  |  | | --- | --- | --- | | Other Medical Conditions (e.g. digestive conditions, gynaecological conditions, hemophilia, etc.): | |  | |  | | | | Of Special Note: (presence of internal pins, wires, artificial joints, special equipment): |  | | |  | | | | | |

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| SIGNATURE: |  | DATE: |  |