Health History Form

The information request 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: _____ Phone # _____
Address: _____ 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 failure
- ☐ 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? (e.g. 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.
_____
_____
_____

Please read carefully and sign: I attest that the information I have provided is true and complete to the best of my knowledge. I understand the information I have provided on this form is confidential and will not be released without my written consent. I consent to therapeutic massage treatment by the above named massage therapist. I also understand that I am responsible for any charges incurred in the course of my treatment. I understand that the treatment may include a 5-10 minute interview and assessment.

Notes:

_____ _____
Signature Date