

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 will be kept confidentially unless allowed or required by law. Your written permission will be required to release any information.

Name _____ Date of birth _____ Occupation _____

Address: _____ City _____ Province _____ Postal Code _____

Phone: Home _____ Work _____ Cell _____ Email _____

Who referred you to our clinic; friend/relative health care practitioner Yellow Pages other

Have you received massage therapy before? yes no

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

Respiratory

- chronic cough shortness of breath bronchitis
 asthma emphysema

Infections

- hepatitis skin conditions TB
 HIV herpes

Head/Neck

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

Woman

pregnant, due _____ gynecological conditions, what? _____

Muscular/bones/joints

- sprain strains broken bone/s
 shoulder separation herniated disc

Other conditions

- loss of sensation arthritis OA or RA diabetes allergies
 epilepsy cancer osteoporosis

Do you have any other medical conditions? (e.g. digestive conditions, hemophilia, mental illness) yes no

Condition _____

Please list any surgical procedures you have had _____

Current medications and what they treat: _____

Any over the counter drugs you are presently taking (e.g. Advil, Tylenol) Taken today? yes no

Are you under any specialist's care? yes no name _____

Present health care: chiropractic Chinese medicine naturopathy/homeopathy other

Primary care physician _____ Address _____

What is the reason you are seeking massage therapy? _____

If you have a specific condition/injury that you are experiencing please complete the following:

How long have you had this condition? _____ Level of discomfort: Mild 1 2 3 4 5 6 7 8 9 10 Severe

Please mark all that apply:

constant intermittent certain movement dull pain achy sharp pain burning tingling swelling

CONSENT FOR MASSAGE THERAPY TREATMENT

I have completed an accurate health history and agree to make known to the therapist should there be any changes to my health, including medication changes. I understand I can ask questions and that if at any time I feel uncomfortable I can ask the therapist to stop or alter the massage. Should I experience any unusual sensations during the massage I will immediately let the therapist know. I understand that by signing this form, I am giving my consent to receive the massage therapy discussed and that my presence at subsequent sessions will be construed to be validation of this written consent. I hereby freely give consent for massage therapy.

Signature _____ Date _____

Please note that we require 24 hrs. notice for cancellation of an appointment, or a fee will be charged.

NOTES:

HEALTH HISTORY UPDATE: