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: _____ Email: _____

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 date: _____

☐ gynecological conditions,
what? _____

Overall, how is your general health?

_____

_____

Primary Care Physician:

_____

Address:

_____

_____

Current Medications: _____

_____

condition(s) being treated: _____

_____

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, hemophilia, 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:

_____

_____

_____

_____

Date of initial health history: _____
Update 1: _____
Update 2: _____
Update 3: _____
Update 4: _____

CONDITION INFORMATION

What is your primary complaint? _____

Can you describe it? ☐ DULL ☐ SHARP ☐ SHOOTING ☐ ACHY ☐ NUMB ☐ TINGLING ☐ STIFF

Pain scale (1 being low; 10 being high): ____ /10

Does is radiate anywhere? _____

Does anything aggravate your symptoms? _____

Does anything relieve your symptoms? _____

When did your symptoms begin? _____

Have they changes and how? _____

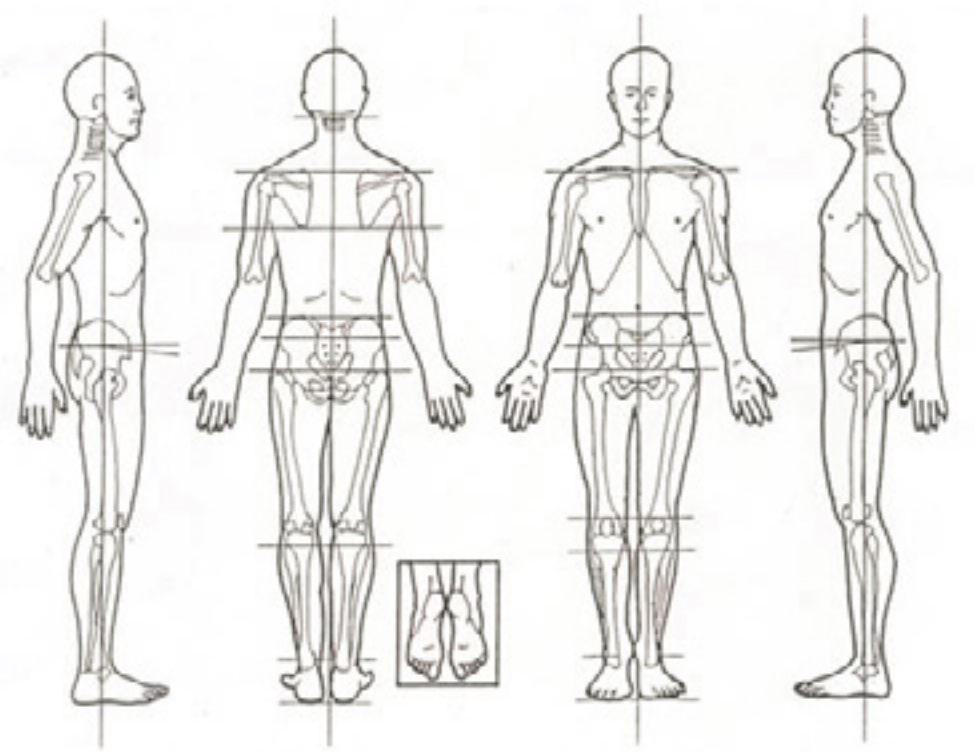
Is this condition interfering with: ☐ WORK ☐ SLEEP ☐ ACTIVITIES of DAILY LIVING

Please explain: _____

_____

ASSESSMENT

On the diagram, please indicate the areas that are causing you pain/discomfort with an ×



I, _____ , have filled out this case history accurately and to the best of my ability.

All the information will be kept confidential between me and my Registered Massage Therapist. A written authorization will be obtained prior to the release of information. I also have the right to stop, change or modify the treatment at any time.

Signature _____ Date _____