

Confidential Health History Form - Massage Therapy

The information contained on this form will be kept confidential and will be used for no other purpose than for your therapist's clinical record. Should any of the information change, please provide us with details in order to provide you with optimum health care. Thank you.

Name: _____ **M** **F** Date: _____

Address: _____ City/Province: _____ Postal Code: _____

Home #: _____ Cell #: _____ Business #: _____

Email Address: _____ How did you hear about us: _____

Date of Birth (M/D/Y): _____ Occupation: _____ Hobbies: _____

Emergency Contact: _____ Phone: _____

Medical Doctor: _____ Phone: _____

How would you rate your current health?: _____

How would you rate your activity Level: **Sedentary** **Light** **Medium** **Athletic**

What are your goals/reasons for seeking massage therapy? _____

Please list **medications/supplements** and the conditions they treat: _____

Do you have any known **allergies**: _____

Are you in pain or discomfort: **Yes** **No** If yes, please describe (location, intensity, quality, etc.)

If no, please indicate any other symptoms (stiffness, numbness, etc.) _____

Are you under care of any other types of health care professionals? _____

Please list any surgeries, injuries or hospitalizations:

Do you use any assistive devices (cane, walker, hearing aid, etc.)? _____

<p>For Office Use Only (Updates)</p> <p>_____</p> <p>_____</p> <p>_____</p>
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Continued on side 2

PLEASE INDICATE ANY APPLICABLE CONDITIONS / SYMPTOMS

(Current and Previous) Please indicate Previous with the letter "P"

Head and Neck:

- Headaches
- Migraines
- Poor Vision
- Hearing Loss
- Glasses / Contact Lenses
- Jaw/Dental Problems
- Whiplash
- Brain Injury / Concussion
- Other _____

Digestive/Urinary Disorders:

- Constipation
- Irritable Bowel Syndrome
- Diabetes Type I or Type II
- Gall Bladder / Liver
- Difficult Digestion
- Ulcers
- Hiatus Hernia
- Diarrhea
- Kidney / Urinary Bladder
- Other _____

Joint & Muscle:

- Neck
- Upper Back
- Mid Back
- Lower Back
- Shoulder
- Hip
- Knee
- Arm / Hand
- Feet
- Other _____

Cardiovascular:

- High Blood Pressure
- Low Blood Pressure
- Heart Disease
- Varicose Veins
- Heart Attack
- Stroke
- Pacemaker
- Poor Circulation
- Other _____

Skin Conditions:

- Psoriasis
- Eczema
- Rashes / Acne
- Sensitivity / Numbness
- Bruise Easily
- Plantar Warts
- Frostbite
- Other _____

Female:

- Painful Periods
- Pregnancy
due date: _____
- Menopause
- Yeast Infections
- Other _____

Respiratory:

- Asthma
- Chronic Cough
- Shortness of Breath
- Bronchitis
- Emphysema
- Allergies/Sinusitis
- Smoker
- Sleep Apnea
- Other _____

Infectious Conditions:

- Tuberculosis
- AIDS/HIV
- Hepatitis
- Infectious Skin Conditions
- Other _____

Diseases/Conditions:

- Cancer
- Arthritis
- Fibromyalgia
- Osteoporosis
- Scoliosis
- Carpal Tunnel
- Multiple Sclerosis
- Epilepsy
- Other _____

This is to confirm and acknowledge that this information is correct and accurate to my knowledge and I give my consent for treatment by a Registered Massage Therapist.

Signature: _____ **Date:** _____