

HEALTH HISTORY FOR MASSAGE THERAPY TREATMENT

For your information: An accurate health history is important to ensure that it is safe for you to receive massage treatment. If your health status changes in the future, please let your therapist know. All information gathered for this treatment is confidential except as required or allowed by law or to facilitate diagnosis (assessment) or treatment. You will be asked to provide written authorization for release of any information.

Name: _____ Date of Initial Visit: _____

Address: _____ City: _____ Postal Code: _____

Home Phone: _____ Work: _____ Other: _____

Date Of Birth: _____ Age: _____ Occupation: _____

Name of Physician: _____ Phone: _____

Have you had Massage Therapy before: Yes No

What is the reason you are seeking massage therapy now? _____

Current Medications and what conditions they are being used for: _____

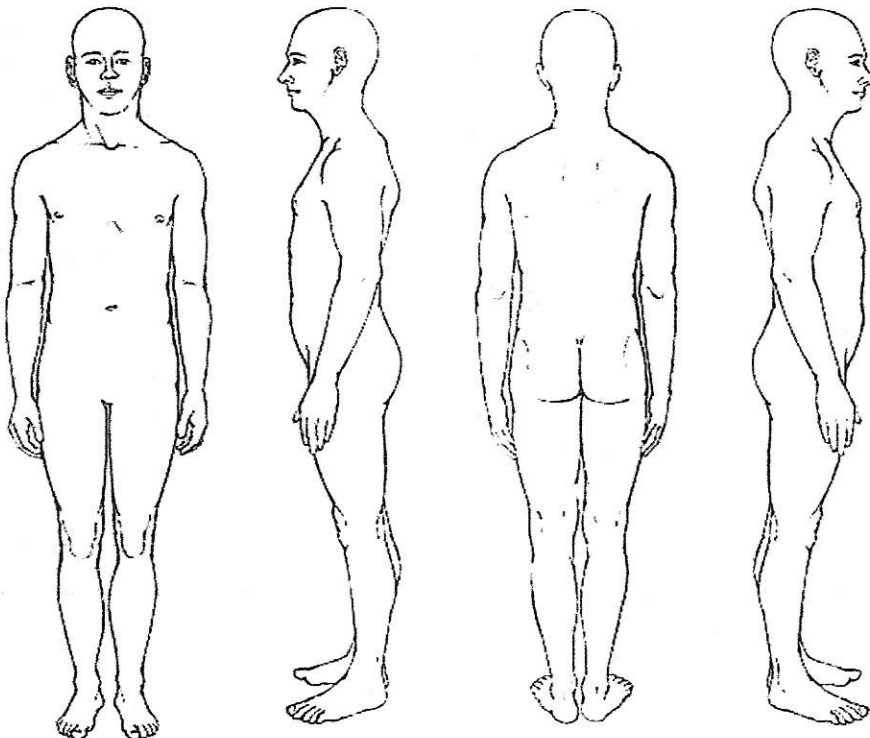
Current involvement in treatment with other health care practitioners: _____

Previous Major illnesses, Operations (Provide dates): _____

Accidents (provide dates): _____

Allergies / hypersensitivities? _____

Please Indicate Areas of soft tissue or joint discomfort



Please check any that apply to you

General Symptoms

- Fainting / Dizziness
- Difficulty sleeping / fatigue
- Stress
- Headaches / Migraines
- Nervousness
- Numbness / Tingling
- Paralysis

Do you have / Had?

- Diabetes
- Cancer
- Epilepsy
- Aneurism / Stroke
- Neuromuscular conditions
- Hypo/hyper glycaemic
- Depression
- Multiple Sclerosis
- Thyroid problems
- Fibromyalgia
- Osteoporosis
- Mental Illness
- Artificial implants/pins/plates
Where _____

Infections

- Hepatitis
- Tuberculosis
- HIV/AIDS
- Herpes
- Athlete's foot
- Warts

Male / Female

- Prostate
- Pregnant; Due date _____
- Menstrual cramping
- Menstrual irregularity
- Birth control
- Breast Pain / Lumps
- Menopausal

Joint/muscle discomfort

- Jaw
- Neck
- Shoulders
- Arms
- Hands
- Upper Back
- Mid Back
- Low Back
- Hips
- Legs
- Knees
- Feet
- Bursitis
- Arthritis
- Family Hx of arthritis

EENT

- Vision problems
- Dental Problems
- Sore throat
- Ear Aches
- Hearing difficulty
- Hearing Aid
- Stuffed nose / sinus
- Allergies
- Swollen Glands

Skin

- Rashes
- Excessive Dryness
- Psoriasis
- Eczema
- skin cancer
- Bruise easily

Lifestyle

- Regular Exercise Yes No Some
- Drink plenty of water Yes No Some
- 8 hrs of sleep nightly Yes No Mostly
- Good eating habits Yes No Mostly

Cardiovascular

- High Blood Pressure
- Low Blood Pressure
- Heart Attack/disease
- Congestive Heart Failure
- Stroke / Aneurism
- Heart Murmur
- Pacemaker
- High Cholesterol
- Swelling of ankles
- Cold hands or feet
- Poor Circulation
- Varicose Veins / Phlebitis
- Family History of: _____

Gastro-intestinal

- Poor / excessive eating
- Excessive thirst
- Gas/bloating
- Colitis
- Crohn's disease
- Constipation
- Diarrhea
- Nausea / Vomiting
- Ulcer
- Abdominal Cramps
- Gall Bladder Problems
- Liver Problems

Respiratory

- Chronic cough
- Bronchitis
- Asthma
- Shortness of breath
- Emphysema
- Family Hx of _____

Signature _____ **Today's Date** _____

For Therapist use only record of Update: