MASSAGE HEALTH HISTORY FORM

RMT Name: _____

The information requested below will assist me in treating you safely. Please feel free to ask any questions about the information being requested. Please note that all information will be kept confidentially unless allowed or required by law. Your written permission will be required to release any information.

NAME: _____ DATE: _____ D.O.B. ____/____/____

ADDRESS: _____ CITY: _____ P.C. _____

PHONE #: (____)_____-_____ CELL #: (____)_____-_____ OTHER: (____)_____-_____

WEIGHT: _____ HEIGHT: ___'___" OCCUPATION: _____ REFERRED BY: _____

OF CHILDREN & AGES: _____ HAVE YOU RECEIVED MASSAGE THERAPY? Y N

DR.'S NAME: _____ ADDRESS: _____ PHONE #: _____

EMAIL ADDRESS: _____

MAY WE COMMUNICATE WITH YOUR DOCTOR CONCERNING YOUR HEALTH? Y N

PLEASE INDICATE CONDITIONS THAT YOU ARE EXPERIENCING OR HAVE EXPERIENCED:

CARDIOVASCULAR
- ☐ High/Low Blood Pressure
- ☐ CCHF
- ☐ Heart Attack & Date: _____
- ☐ Phlebitiz/Varicose Veins
- ☐ Stroke/CVA & Date: _____
- ☐ Pacemaker/Similar Device
- ☐ Heart Disease

RESPIRATORY
- ☐ Chronic Cough
- ☐ Bronchitis
- ☐ Emphysema
- ☐ Shortness of Breath
- ☐ Asthma

INFECTIONS
- ☐ Hepatitis
- ☐ Skin Conditions Types: _____
- ☐ TB
- ☐ HIV
- ☐ Herpes & Type: _____

HEAD / NECK
- ☐ Headaches
- ☐ Migraines
- ☐ Vision Problems
- ☐ Ear Problems

DIGESTIVE
- ☐ Constipation
- ☐ Diarrhea
- ☐ Difficult Digestion
- ☐ IBS

WOMAN
- ☐ Pregnant? Due: _____
- ☐ Menstrual Problems What?: _____
- ☐ Menopause
- ☐ Caesarian Section
- ☐ Gynecological Conditions?
  What: _____

OTHER CONDITIONS
- ☐ Loss of Sensation? Where? _____
- ☐ Pins & Needles? Where? _____
- ☐ Diabetes Type: _____ Onset: _____
- ☐ Allergies? What? _____
- ☐ Epilespy
- ☐ Cancer & Location: _____
- ☐ Arthritis -Type & Location: _____
- ☐ Sinusitis
- ☐ TMJ
- ☐ Cold Hands &/or Feet
- ☐ Osteoporosis
- ☐ Hemophilia
- ☐ Mental Illness & Type: _____
- ☐ Other: _____

MUSCLE DISCOMFORT
- ☐ Neck
- ☐ Shoulders L R
- ☐ Back - Upper Mid Low
- ☐ Legs L R
- ☐ Knees L R
- ☐ Arms L R
- ☐ Feet L R
- ☐ Hands L R
- ☐ Other: _____

CURRENT MEDICATION & CONDITION IT TREATS:

1. _____
2. _____
3. _____
4. _____

HAVE YOU EVER HAD SURGERY? Y
Date: _____
Location: _____
Type: _____

HAVE YOU EVER BEEN IN A MOTOR VEHICLE ACCIDENT? Y N
Date: _____
Injuries: _____

HAVE YOU EVER HAD ANY MAJOR INJURIES? Y N
Date: _____
Type: _____

DO YOU PARTICIPATE IN REGULAR EXERCISE? Y N
If Yes, What & Frequency: _____

ARE YOU CURRENTLY RECEIVING TREATMENT FROM ANOTHER HEALTH CARE PROFESSIONAL? Y N
If Yes, What? _____

OVERALL HOW IS YOUR GENERAL HEALTH? _____

WHAT IS YOUR PRIMARY COMPLAINT? _____

DO YOU HAVE ANY INTERNAL WIRES, PINS, PLATES, ARTIFICIAL JOINTS OR SPECIAL EQUIPMENT? Y N
If Yes, What & Where? _____

HEALTH HISTORY UPDATES:

1. _____
2. _____
3. _____
4. _____

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