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:______________

____

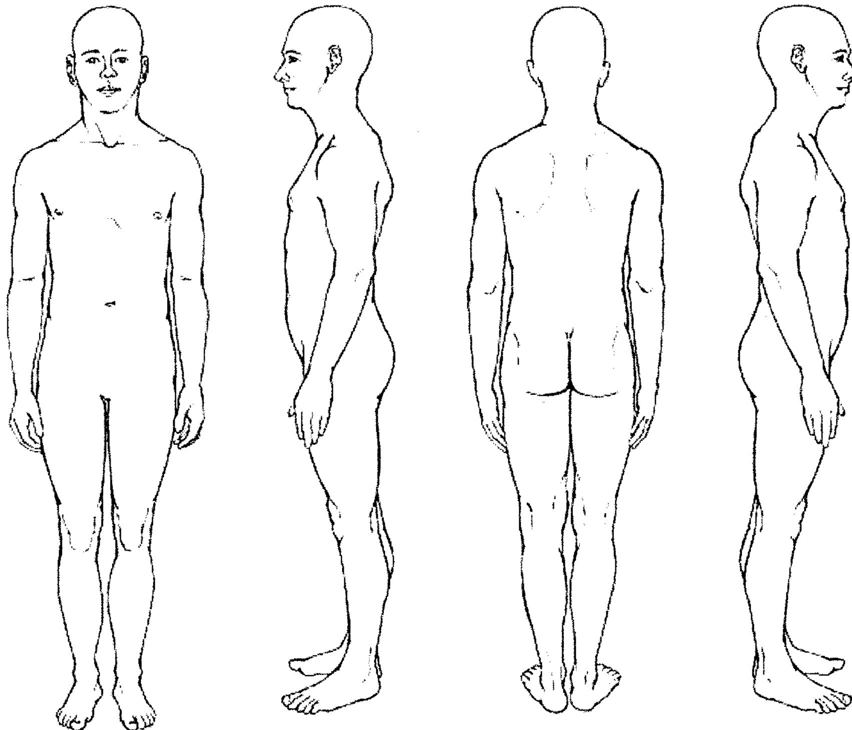
Current involvement in treatment with other health care practitioners:___________

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

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 ____________

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

Signature ____________________________ **Today's Date** ____________________

For Therapist use only record of Update: