

Massage Therapy Health History Form

An accurate Health History is important to ensure that it is safe for you to receive a massage treatment. If your health status changes in the future, please let me know. All information gathered for this treatment is confidential except as required by law. You will be asked to provide written authorization for release of any information.

Date _____

Last Name _____ First Name _____ Initial _____

Mailing Address _____ Apt. _____

City/Province _____ Postal Code _____ Email _____

Day Phone: _____ Eve. Phone: _____

Who referred you to this clinic? Name Yellow Pages Advertisement Sign Other: _____

Birth Date: (m) _____ (d) _____ (y) _____ Sex: M F

Primary Health Care Physician: _____

Occupation: _____ Place of Employment _____

What is your primary complaint or condition you want to improve? _____

What symptoms are you experiencing? _____

When did you first notice major complaints? _____

What brought it on? _____

What activities aggravate this condition? _____

Is this condition getting progressively worse? Yes No Please Explain: _____

Does this condition interfere with work? Yes No Sleep? Yes No Daily Routine? Yes No

What have you done to get relief? _____

Have you had a CT Scan take? Yes No MRI? Yes No

If yes for what condition? _____ When? _____

Health History: Please indicate conditions you are experiencing, or have experienced.

- Cardiovascular**
- High Blood Pressure
 - Low Blood Pressure
 - CCHF
 - Heart Attack
 - Phlebitis
 - Stroke
 - Pacemaker (or similar device)
 - Varicose Veins
 - Dizziness/Fainting
 - Chronic Cough
 - Shortness of Breath
 - Bronchitis
 - Asthma
 - Emphysema

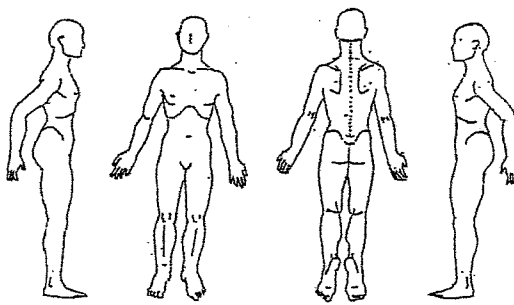
- Musculo-Skeletal**
- Headaches
 - Joint Stiffness/Swelling
 - Spasms/Cramps
 - Broken/Fractured Bones
 - Strains/Sprains
 - Other _____

- Soft Tissue/Joint Discomfort**
- Neck
 - Upper Back
 - Shoulder
 - Mid-back
 - Low-back
 - Legs
 - Arms
 - Other _____

- Other Conditions**
- Diabetes: Type _____
 - Loss of Sensation
 - Arthritis: Type _____
 - Allergies
 - Cancer _____
 - Constipation
 - Diarrhea
 - Vision Problems/Loss
 - Ear Problems
 - Sleep Disorders
 - Other: _____

- Lifestyle**
- Regular Exercise
 - Alcohol
 - Medications
 - Caffeine _____ cups/day
 - Cigarettes _____ /day
 - Water _____ glasses/day

Indicate Areas of Complaint (x)



Massage Therapy Health History Form (continued)

Describe the exercise activities you do (include frequency): _____

Please list (date and description) any accidents or surgeries: _____

What are your expectations for this visit? _____

Are you now under medical/therapeutic treatment? Yes No

If yes, for what condition? _____

List any medications (including aspirin) and nutritional supplements you are taking and it's frequency:
_____- (condition it treats) _____
_____- (condition it treats) _____
_____- (condition it treats) _____
_____- (condition it treats) _____
_____- (condition it treats) _____
_____- (condition it treats) _____

Please list any additional comments regarding your health and well-being: _____

In case of emergency, please notify:
Name: _____ Relationship: _____
Telephone #: (res) _____ (bus) _____ (cell) _____

I have stated all conditions that I am aware of and this information is true and accurate. I will inform my Massage Therapist of any changes in my status.

Patient Signature: _____ Date: _____