Confidential Health History Form

An accurate health history is important to insure that it is safe for you to receive a massage treatment. All information gathered for this treatment is confidential except as required by law. Written authorization will be required for release of any information.

Name: _____ Email: _____.

Home: (____) _____ Work: (____) _____ Cell: (____) _____.

Address: _____ City: _____ Postal Code: _____.

Date of Birth: ___/___/___. (d/m/y) Occupation: _____ First time for Massage Therapy: YES/NO

Family Physician: _____ Address: _____.

Who can we thank for referring you here? _____ If Doctor- Address: _____.

Reason for Massage Therapy Treatment: _____.

_____.

Health History: Please check spaces below for any conditions that you are experiencing or have experienced.

Soft tissue/ Joints

- ☐ Tendonitis/ Bursitis
- ☐ Weakness _____.
- ☐ Sprains/ Strains
- ☐ Arthritis- OA/ RA/ other
  Location: _____.
- ☐ Herniated Discs

Headaches

- ☐ Tension Headaches
- ☐ Migraines
- ☐ Tooth/jaw/ ear pain
- ☐ Head Trauma- date: _____.

Accident/Injury

- ☐ Car Accident
- ☐ Whiplash
  Date: _____.
  Symptoms: _____.
  _____.
- ☐ Fractures

Women

- ☐ Pregnant- due date: _____.
- ☐ Gynaecological Conditions

Surgery

Type: _____.
Date: _____.
Current Symptoms: _____.

Current Medications & Conditions

_____.
_____.

Respiratory

- ☐ Chronic Cough
- ☐ Shortness of breath
- ☐ Bronchitis
- ☐ Asthma
- ☐ Emphysema
- ☐ Pneumonia
- ☐ Sinus Problems

Cardiovascular

- ☐ High Blood Pressure
- ☐ Low Blood Pressure
- ☐ Heart Attack
- ☐ Phlebitis
- ☐ Stroke/ CVA
- ☐ Pacemaker
- ☐ Heart Disease
- ☐ Angina
- ☐ Chronic Congestive Heart Failure

Infectious Disease

- ☐ Hepatitis
- ☐ Tuberculosis
- ☐ HIV/AIDS
- ☐ Other: _____.

Skin

- ☐ Bruise Easily
- ☐ Herpes
- ☐ Varicose Veins
- ☐ Athletes Foot
- ☐ Warts/ Plantar Warts
- ☐ Loss of Sensation
- ☐ Other

Other Conditions

- ☐ Neurological conditions
- ☐ Epilepsy
- ☐ Diabetes- onset: _____.
- ☐ Allergies- **Anaphylaxis Y/N**
- ☐ Cancer: _____.
- ☐ Vision Problems
- ☐ Hearing loss or Tinitis
- ☐ Constipation
- ☐ Other Digestive Conditions:
  _____.
- ☐ Insomnia/ Poor sleeping patterns
- ☐ Kidney/ Bladder Problems
- ☐ Hemophilia
- ☐ Fibromyalgia
- ☐ Osteoporosis
- ☐ Surgical Implants (pins, plates, etc.)

Present Involvement in Other Healthcare: YES/NO

If yes, specify: _____.

General Health Status: Excellent / Good / Fair / Poor **Family History of Arthritis?** YES / NO

_____.

I have read the above information and have stated all my previous and current medical conditions. I take it upon myself to update the massage therapist regarding any changes in my condition. I understand that all massage treatments will be discussed and planned with the massage therapist, and will require my informed consent.

Signature: _____ **Date:** _____.

Update 1: _____.
Update 2: _____.
Update 3: _____.