CONFIDENTIAL HEALTH HISTORY FORM

For your information:

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 or allowed by law or except to facilitate diagnosis (assessment) or treatment. You will be asked to provide authorization for release of any information.

NAME: _____ CONTACT #: HOME _____

ADDRESS: _____ BUS. _____

_____ CELL _____

DATE OF BIRTH: _____ M ( ) / F ( ) EMAIL: _____

OCCUPATION: _____ WEIGHT: _____ HEIGHT: _____

PRIMARY CARE PHYSICIAN: _____ ADDRESS/PHONE #: _____

What is your primary complaint? _____

Who referred you? _____

Any previous treatment for the above complaint by a :

Massage therapist ( ) Chiropractor ( ) Physiotherapist ( ) Medical Doctor ( ) Other ( )

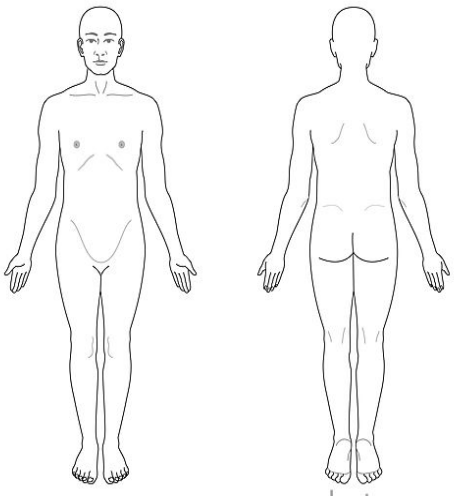
Current Medications: _____ _____ _____

Condition Treated: _____ _____ _____

Surgery: _____ Date: _____ Nature: _____

Injury: _____ Date: _____ Nature: _____

Please indicate: Pain with "O" Joint and muscle stiffness with "X" Numbness and tingling with "N"



Please indicate if you have any of the following conditions:

CARDIOVASCULAR

( ) high blood pressure

( ) low blood pressure

( ) chronic congestive heart failure

( ) heart attack

( ) phlebitis/varicose veins

( ) stroke/CVA

( ) pacemaker or similar device

( ) heart disease

Any family history of the above?

Yes ( ) No ( )

RESPIRATORY

( ) asthma

( ) chronic cough

( ) shortness of breath

( ) bronchitis

( ) emphysema

Any family history of the above?

Yes ( ) No ( )

HEAD/ NECK

( ) history of headaches

( ) history of migraines

( ) vision loss

( ) vision problems

( ) ear problems

( ) hearing loss

SKIN

( ) skin condition

_____

( ) bruise easily

( ) plantar wart

( ) rashes

( ) loss of sensation

Where? _____

( ) eczema/psoriasis

Where? _____

INFECTIONS

( ) hepatitis

( ) TB

( ) AIDS/HIV

( ) herpes

( ) skin conditions

DIGESTIVE/URINARY

( ) difficult digestion

( ) constipation

( ) liver/gallbladder

( ) kidney/bladder

( ) Chrone's disease/colitis

( ) ulcers

SURGICAL IMPLANTS

( ) pins _____

( ) wires _____

( ) artificial joint/limb _____

( ) other _____

OTHER CONDITIONS

( ) hemophilia

( ) epilepsy

( ) osteoporosis

( ) cancer

Type: _____

( ) arthritis: ( ) OA ( ) RA

( ) fibromyalgia

( ) chronic fatigue syndrome

( ) polio

( ) scoliosis

( ) carpal tunnel syndrome

FEMALE

( ) menstrual problems

_____

( ) pregnant, # weeks _____

Due: _____

( ) menopause problems

_____

UPDATE 1 _____

UPDATE 2 _____

UPDATE 3 _____

UPDATE 4 _____

UPDATE 5 _____

SIGNATURE:

_____

DATE:

_____

CONSENT TO TREATMENT

I, _____ of my own free will, do consent to treatment

for the following reasons:

_____

_____

_____

_____

I acknowledge that my therapist will provide me with such information as is pertinent to my treatment of the above listed complaints.

Courses of treatment where applicable have been explained to me as well as the possible advantages and disadvantages of treatment.

I appreciate that my consent herein provided may be terminated at any time.

This agreement is signed voluntarily and not under any form of duress.

NAME: _____

SIGNATURE: _____

DATE: _____