Massage Therapy Health History Form

For your information:
An accurate health history is important to ensure that you receive a safe and effective massage therapy treatment. If your health status changes in the future, please let us know. All information gathered for this treatment is confidential except as required or allowed by law. You will be asked to provide written authorization for release of any information.

Name: _____ Date: _____

Address: _____ Tel: hm. _____

_____ Wk. _____

Date of Birth: _____ Occupation: _____ Email: _____

Who referred you? _____ What is your primary complaint? _____

Secondary complaint? _____

Is this your first massage ☐ Yes ☐ No

Health History: (please indicate the conditions that you are currently experiencing or have experienced in the past)

HEAD/NECK
- ❑ Headaches
- ❑ (type) _____
- ❑ Vision problems
- ❑ Contact lenses
- ❑ Earaches
- ❑ Dizziness
- ❑ Hearing loss
- ❑ Family history of above

RESPIRATORY
- ❑ Chronic cough
- ❑ Shortness of breath
- ❑ Smoker
- ❑ Asthma
- ❑ Emphysema
- ❑ Bronchitis
- ❑ Family history of above
- ❑ Other

_____

CARDIOVASCULAR
- ❑ High blood pressure
- ❑ Low blood pressure
- ❑ Poor circulation
- ❑ C.O.P.D.
- ❑ Heart attack
- ❑ Phlebitis
- ❑ Stroke
- ❑ Pace maker or similar device
- ❑ Family history of above

MUSCLES & JOINTS
- ❑ Stiffness
- ❑ Swelling
- ❑ Neck pain
- ❑ Lower back pain
- ❑ Upper back / shoulder pain
- ❑ Pain in limbs
- ❑ Pins and needles in limbs
- ❑ Whiplash
- ❑ Rheumatoid arthritis
- ❑ Osteoarthritis
- ❑ Family history of above
- ❑ Other

_____

_____

SKIN
- ❑ Sensitive skin
- ❑ Bruise easily
- ❑ Varicose veins

Dr. diagnosed? _____

WOMEN
- ❑ PMS
- ❑ Menopause
- ❑ Caesarian or other gynecological surgery
- ❑ Pregnant

Due date: _____

MEN
- ❑ Prostate cancer
- ❑ Erectile difficulties
- ❑ Other _____

INFECTIONS
- ❑ Herpes
- ❑ Hepatitis
- ❑ Plantar warts
- ❑ Skin conditions
- ❑ Tuberculosis
- ❑ HIV/AIDS
- ❑ Other

_____

OTHER CONDITIONS
- ❑ Difficult digestion
- ❑ Constipation
- ❑ Liver
- ❑ Gallbladder
- ❑ Kidney
- ❑ Bladder
- ❑ Diabetes (onset:)
- ❑ Sinus
- ❑ Allergies
- ❑ Insomnia
- ❑ Cancer
- ❑ Arthritis
- ❑ Epilepsy
- ❑ Depression
- ❑ Family history of above
- ❑ Other

_____

Confidential Massage Patient Information

How would you describe your general overall health: _____

Current Medications: _____ Primary Care Physician: _____

Condition it treats: _____ Address: _____

Surgery: _____ Date: _____ Phone: _____

Nature: _____ Present Involvement in Other Heath care: ☐ yes ☐ no

Injury: _____ Date: _____ If yes , please specify: _____

Nature: _____ _____

Other Medical Conditions (e.g. digestive or gynaecological conditions, osteoporosis, hemophilia etc.): _____

_____

Of Special Note (presence of internal pins, wires, artificial joints, special equipment): _____

_____

Additional Information:

_____

_____

_____

_____

Informed Consent

It is my choice to receive massage therapy. I understand that the treatment is being given for the well being of my body and mind. I agree to communicate with my therapist any time I feel that my well being is compromised. I understand that the therapist will outline the treatment and will commence treatment once consent has been obtained. I understand that I may stop the treatment at any time I may choose to do so. I understand that the massage therapists do not diagnose illness, disease or any physical or mental disorder; nor do they prescribe medical treatment, pharmaceuticals or perform spinal thrust manipulations. I acknowledge that massage is not a substitute for medical examinations or diagnosis and that it is recommended that I see a primary health care provider for that service.

Payment is due at the time of service, unless prior arrangements have been made. I am aware of the cancellation policy requiring 24 hours notification. If notice is not given, missed appointments will be billed in full.

Signature **Date**