

This Health History Form will assist me in providing you with a safe and an effective treatment. You must notify us of any changes in your health status. Please feel free to ask questions regarding the health history form.

Please note that all information provided is strictly confidential and will not be released to anyone without your prior written permission. Updated

Name: _____ D.O.B. (mm/dd/year): _____

Address: _____ City & Prov: _____ Postal Code: _____

Tel #1: _____ Tel #2: _____ E-Mail: _____

Emergency Contact Name: _____ Tel: _____

Occupation: _____ Family doctor: _____

Ever had massage before? Yes No

Reason for Seeking Massage Today? (Specify when and how you were injured) _____

How did you hear about us? (Indicate name) _____

How would you characterize your general health? _____

Activities of Daily Living Disrupted by the presence of your condition _____

Main Area(S) you wish me to focus on today (Specify) _____

Medications (Specify their names, and what they treat) _____

PLEASE MARK ANY OF THE CONDITIONS LISTED BELOW, THAT APPLY TO YOU:

RESPIRATORY SYSTEM CONDITIONS

Chronic Cough Emphysema Asthma Chronic Bronchitis Shortness of Breath
Infectious Respiratory Conditions (sore/strep throat, etc.)

Do you smoke? Yes No

Family history of Respiratory Conditions? (Specify) _____

Flip this page over to continue

CARDIOVASCULAR SYSTEM CONDITIONS

Heart Attack Stroke Pacemaker Aneurism Hi/Low BP Heart Disease
Varicose Veins Atherosclerosis Bleed Disorder DVT (Clots) Heaviness in Limbs

Family history of Cardiovascular Conditions? (Specify) _____

DIGESTIVE SYSTEM CONDITIONS

Eating Disorders Abnormal Bowel Movements IBS

Family history of Digestive Disorders? (List) _____

INTEGUMENTARY SYSTEM CONDITIONS (SKIN)

Allergy to Heat Allergy to Cold Allergy to oils Eczema Psoriasis Acne
Current Rashes/cuts/abrasions Current Open Sores/Wounds Cysts
Swelling Anywhere Hives

Any Other Allergies: (Specify) _____

OSTEOLOGY SYSTEM CONDITIONS (BONES)

Osteoporosis Osteoarthritis Rheumatoid Arthritis
Disc Disease Surgery (Pins – Screws – Plates – Wires)?

Family history of bone disorders? (Specify) _____

NERVOUS SYSTEM CONDITIONS

Seizures Epilepsy Hearing Impairment Sight Impairment Shakiness in Limbs
Headaches (Specify) Sensory Impairment - Pins or Needles (Specify)

Family history of neurological disorders? (Specify) _____

INFECTIOUS CONDITIONS

Hepatitis Herpes Warts Foot fungus Poison Ivy/Oak/Parsnip/Sumac

STD/HPV/HIV (Specify) _____

MISCELLANEOUS CONDITIONS

Pregnant Diabetes Hernia Cancer Haemophilia Mental Illness

Is any of the above information you provided, recent? (Last 6 months) _____

I, the undersigned, acknowledge that the information I filled out on this Health History Form, is accurate, and complete.

Signature

Date

Updated: _____: Updated: _____: Updated: _____:
 Updated: _____: Updated: _____: Updated: _____: