

Massage Therapy Health History Form

The information request below will assist us in treating you safely. Feel free to ask any questions about the information being requested. Please note that all information provided below will be kept confidentially unless allowed or required by law. Your written permission will be required to release any information.

Name : _____ Date: _____

Have you received massage therapy before ? Yes No

Did a health care practitioner refer you for massage therapy ? Yes No

If yes, please provide their name and address. _____

Please indicate conditions you are experiencing or have experienced.

<p><u>Cardiovascular</u></p> <ul style="list-style-type: none"> <input type="radio"/> high blood pressure <input type="radio"/> low blood pressure <input type="radio"/> chronic congestive heart failure <input type="radio"/> heart attack <input type="radio"/> phlebitis / varicose veins <input type="radio"/> stroke / CVA <input type="radio"/> pacemaker or similar device <input type="radio"/> heart disease <p>is there a family history of any of the above ? Yes <input type="radio"/> No <input type="radio"/></p> <p><u>Respiratory</u></p> <ul style="list-style-type: none"> <input type="radio"/> chronic cough <input type="radio"/> shortness of breath <input type="radio"/> bronchitis <input type="radio"/> asthma <input type="radio"/> emphysema <p>is there a family history of any of the above ? Yes <input type="radio"/> No <input type="radio"/></p>	<p><u>Infections</u></p> <ul style="list-style-type: none"> <input type="radio"/> hepatitis <input type="radio"/> skin conditions <input type="radio"/> TB <input type="radio"/> HIV <input type="radio"/> herpes <p><u>Other Conditions</u></p> <ul style="list-style-type: none"> <input type="radio"/> loss of sensation, where ? _____ <input type="radio"/> diabetes, onset : _____ <input type="radio"/> allergies/hypersensitivity to what ? _____ <p>Type of reaction : _____</p> <ul style="list-style-type: none"> <input type="radio"/> epilepsy <input type="radio"/> cancer, where ? _____ <input type="radio"/> skin condition, what ? _____ <ul style="list-style-type: none"> <input type="radio"/> arthritis <p>is there a family history of arthritis ? Yes <input type="radio"/> No <input type="radio"/></p>	<p><u>Head/Neck</u></p> <ul style="list-style-type: none"> <input type="radio"/> history of headaches <input type="radio"/> history of migraines <input type="radio"/> vision problems <input type="radio"/> vision loss <input type="radio"/> ear problems <input type="radio"/> hearing loss <p><u>Women</u></p> <ul style="list-style-type: none"> <input type="radio"/> pregnant, due : _____ <input type="radio"/> gynecological conditions, what ? _____ <p>Overall, how is your general health ? _____</p> <p>Primary Care Physician : _____</p> <p>Address : _____ _____ _____</p>
<p>Current Medications : _____</p> <p>Condition it treats _____</p> <p>Are you currently receiving treatment from another health care Professional ? Yes <input type="radio"/> No <input type="radio"/></p> <p>If yes, for what ? _____</p> <p>Surgery – date : _____</p> <p>Nature _____</p> <p>Injury – date : _____</p> <p>Nature : _____</p>		<p>Do you have any other medical conditions ? (e.g. digestive conditions, hemophilia, osteoporosis, mental illness) Yes <input type="radio"/> No <input type="radio"/></p> <p>What ? _____</p> <p>Do you have any internal pins, wires, artificial joints or special equipment ? Yes <input type="radio"/> No <input type="radio"/></p> <p>What ? _____</p> <p>Where ? _____</p> <p>What is the reason you are seeking massage therapy ? Please include the location of any muscle or joint discomfort ? _____ _____ _____</p>

Signature : _____

Date : _____