

Health History Form

The information request below will assist us in treating you safely. Feel free to ask any question 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: _____ Phone: _____
 Address: _____ Date of Birth: _____
 Occupation: _____

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:

Cardiovascular

- ☐ high blood pressure
- ☐ low blood pressure
- ☐ chronic congestive heart failure
- ☐ heart attacks
- ☐ phlebitis/varicose veins
- ☐ stroke/CVA
- ☐ pacemaker or similar device
- ☐ heart disease

Is there a family history of
 Any of the above? ☐ Yes ☐ No ☐

Respiratory

- ☐ chronic cough
- ☐ shortness of breath
- ☐ asthma
- ☐ emphysema

Is there a family history of any
 of the above ☐ yes ☐ no

Infections

- ☐ hepatitis
- ☐ skin conditions
- ☐ TB
- ☐ HIV
- ☐ herpes

Other conditions

- ☐ loss of sensation, where? _____

☐ diabetes, onset _____
 allergies/hypersensitivity to
 What _____

Type of reaction: _____

- ☐ epilepsy
- ☐ cancer, where? _____
- ☐ skin conditions, What? _____
- ☐ arthritis

is there a family history of
 arthritis? ☐ yes ☐ no

Head/Neck

- ☐ history of headaches
- ☐ history of migraines
- ☐ vision problems
- ☐ vision loss
- ☐ ear problems
- ☐ hearing loss

Women

- ☐ pregnant, due: _____

☐ gynaecological conditions, what _____
 Overall, how is your general health? _____

Primary Care Physician: _____

Address: _____

Current Medications:

Condition it treats: _____

Are you currently receiving treatment from
 Another health care professional? ☐ yes ☐ no

Surgery – date _____

Nature: _____

Injury- date _____

Nature _____

Do you have any other medical conditions? (e.g digestive
 conditions, haemophilia, osteoporosis, mental illness)

☐ yes ☐ no

what? _____

Where? _____

Do you have any internal pins, wires, artificial joints or
 special equipment? ☐ yes ☐ no

What? _____

Where? _____

What is the reason you are seeking massage therapy?

Please include the location of any tissue or joint

Discomfort. _____
