Health History Form

FYI: an accurate health history ensures that it is safe for you to receive a massage treatment, and helps the therapist determine a proper treatment plan. When your health status changes in the future, please let us know. All information gathered on this form is confidential. Your written authorization is legally required before any of this information can be released.

Personal Information

Name: _____ Date: _____

Address: _____ City: _____ Postal Code: _____

Home Phone: _____ Work Phone: _____ Occupation: _____

Date of Birth: _____ Email: _____ Height: _____ Weight:_____

Doctor: _____ Phone: _____ May I contact? ¨Yes ¨No

Emergency Contact Name: _____ Phone: _____

Have you had a massage before? ¨Yes ¨No For relaxation or other reason?: _____

Current Medications: _____

Previous Major Illnesses, Operations: _____

Accidents (please give dates): _____

_____

Other Medical Conditions (e.g. hemophilia, diabetes): _____

Family history (major illnesses, operations): _____

Please indicate all conditions you have experienced. Mark C for current or P for past.

Joint/Soft Tissue Discomfort:
__ Arms
__ Upper Back
__ Mid Back
__ Lower Back
__ Degenerative Discs
__ Feet
__ Hands
__ Hips
__ Jaw
__ Knees
__ Legs
__ Neck
__ Osteo Arthritis
__ Rheumatoid Arthritis
__ Sciatica
__ Shoulders
__ Limitation of Movement
in which joints: _____
Other _____

Skin:
__Rashes
__Itching
__Bruise Easily
__Dryness
__Boils
Other _____

General Symptoms:
__ Fainting
__ Dizziness
__ Loss of Sleep
__ Fatigue
__ Nervousness
__ Sudden Weight Loss/Gain
__ Numbness
__ Tingling
__ Paralysis
__ Headaches (Tension)
__ Migraines

Cardiovascular:
__ High Blood Pressure
__ Low Blood Pressure
__ Coronary Heart Disease
__ Heart Attack
__ Phlebitis
__ Stroke / CVA
__ Pacemaker
__ Heart Murmur
__ Palpitations
__ Varicose Veins
__ Swelling of the Ankles
__ Poor Circulation

Infectious:
__ Hepatitis
__ Tuberculosis
__ Human Immunodeficiency Virus (HIV)
__ Herpes
__ Cold
__ Flu
__ Athlete's Foot
__ Warts
Other _____

Digestive:
__ Poor Appetite
__ Belching/Gas
__ Constipation
__ Diarrhea
__ Nausea
__ Ulcer
__ Vomiting

Eye, Ear, Nose, Throat:
__ Allergies
__ Frequent Colds
__ Glasses or Contacts
__ Hearing Aid
__ Hearing Loss
__ Sinus Infection
__ Swollen Glands

(continued on reverse)

Client Name:

Please indicate all conditions you have experienced. Mark C for current or P for past.

Reproductive:
__ Pregnant
due date _____
__ Painful Menstruation
__ Heavy Flow
__ Irregular Cycle
__ Swollen Breasts
__ Menopausal
__ Pre-menopausal

Respiratory:
__ Chronic Cough
__ Bronchitis
__ Asthma
__ Hay Fever
__ Difficulty Breathing
__ Smoking
__ Emphysema
__ Pneumonia

Lifestyle Questions

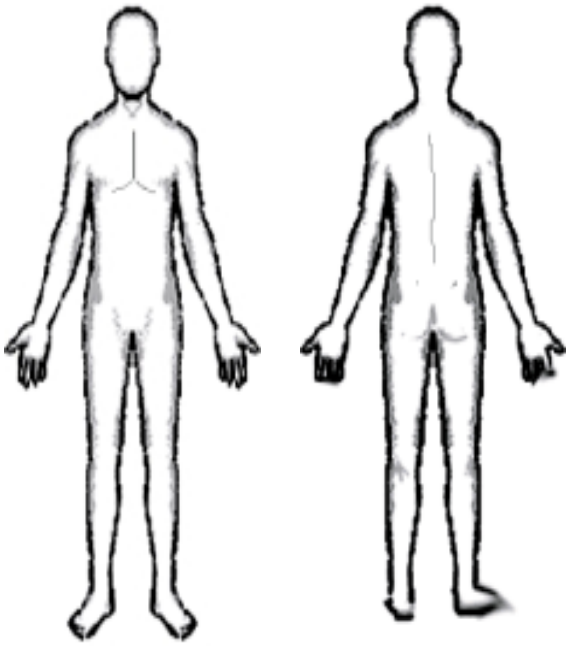
Regular eating habits ☐Yes ☐No
Do you take vitamins: ☐Yes ☐No
Type: _____
Frequency: _____
Regular exercise ☐Yes ☐No
Type: _____
Frequency: _____

Energy Level: ☐High ☐Average ☐Low
Do you suffer from stress? ☐Yes ☐No
Type: _____
Do you use a computer? ☐Yes ☐No
How many hours per day: _____

Please read carefully, and sign.

I attest that the information I have provided is true and complete to the best of my knowledge.
I understand the information I have provided on this form is confidential and will not be released without my written consent.
I consent to therapeutic massage treatment by the above named massage therapist.
I also understand that I am responsible for any charges incurred in the course of my treatment.
I understand that 24 hours notice is required to reschedule all future appointments, or full charges will apply.

_____ _____
signature today's date



circle any focal areas

This area to be filled out by the therapist.

Duration of Massage: _____ Cost: _____

Techniques Used: _____

_____

_____

Comments: _____

_____

Self Care Recommendations: _____

_____

__ Post-menopausal
__ Birth control
type _____

Client Name: