

HEALTH HISTORY FORM

An accurate health history is important to ensure that it is safe for you to receive a massage treatment. If your health status changes in the future, please let me know. All information gathered for this treatment is confidential except as required or allowed by law or except to facilitate diagnosis (assessment) or treatment. You will be asked to provide written authorization for release of any information.

Please fill in the following:

Your name, address, home and work phone numbers	
Date of birth:	Occupation:
Name, address and phone number of your family physician	
Were you referred for massage therapy by a health care professional? <input type="checkbox"/> Yes <input type="checkbox"/> No	
If yes, please provide their name and address	
How is your health overall? What is your primary reason for receiving massage therapy, including the location of any tissue or joint discomfort.	
Have you had massage therapy before? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, did you suffer any adverse reactions? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Please list below any treatment you receiving from other health care practitioners; any medications you are taking and the conditions that they are treating; the date and nature of any surgeries, injuries and/or accidents; the location of any internal pins, wires, artificial joints and/or special equipment.	

Do you have any of the following health conditions (please check all that apply):

- | | | |
|--|---|--|
| <input type="checkbox"/> high blood pressure | <input type="checkbox"/> vision loss | <input type="checkbox"/> emphysema |
| <input type="checkbox"/> low blood pressure | <input type="checkbox"/> hearing loss | <input type="checkbox"/> shortness of breath |
| <input type="checkbox"/> chronic congestive heart failure | <input type="checkbox"/> loss of sensation | <input type="checkbox"/> asthma |
| <input type="checkbox"/> history of cerebro-vascular accident | <input type="checkbox"/> diabetes | <input type="checkbox"/> bronchitis |
| <input type="checkbox"/> history of myocardial infarction | <input type="checkbox"/> epilepsy | <input type="checkbox"/> chronic cough |
| <input type="checkbox"/> plebitis | <input type="checkbox"/> hepatitis | <input type="checkbox"/> arthritis |
| <input type="checkbox"/> pacemaker or similar device | <input type="checkbox"/> cancer | <input type="checkbox"/> tuberculosis |
| <input type="checkbox"/> heart disease | <input type="checkbox"/> AIDS / HIV | <input type="checkbox"/> influenza |
| <input type="checkbox"/> blood conditions including hymophilia | <input type="checkbox"/> digestive conditions | <input type="checkbox"/> skin conditions |
| <input type="checkbox"/> other infectious conditions | <input type="checkbox"/> allergies or hypersensitivities where the response is anaphylaxis or skin irritation | |

For women only:

Are you pregnant? Yes No

Do you have any gynaecological conditions? Yes No

Notes:

Date of initial Health History: _____
Update 1 _____
Update 2 _____
Update 3 _____
Update 4 _____
Update 5 _____