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# Massage Therapy Health History Form

An accurate health history is important to ensure that it is safe for you to receive a massage treatment. All information gathered for this treatment is confidential except as required or allowed by law. Written authorization will be required for release of any information. **24 hour cancellation notice is required otherwise a missed appointment fee (half of the price of the scheduled massage) will be charged. This form must be updated annually.**

**First Name:** _____ **Last Name:** _____
**Address:** _____ **Tel. Home:** _____
**City:** _____ **Province:** _____ **Tel. Bus:** _____
**Postal Code:** _____ **Date of Birth:** MM / DD / YY **Tel. Cell:** _____
**Gender: M / F Occupation:** _____ **Email:** _____
**Primary Health Care Physician:** _____ ❑ **Health Practitioner's Referral:** _____
**Address:** _____ **Tel No:** _____ **Address of Health Practitioner:** _____
❑**Others Referral:** _____
**Emergency Contact Person:** _____**Emergency Contact Person Tel:**_____
**1st Massage Therapy Treatment: Yes/No** **General Health Status:** _____
**Primary Complaint:** _____

**Cardiovascular**
- ❑ high blood pressure
- ❑ low blood pressure
- ❑ heart attack, date:_____
- ❑ stroke/CVA, date:_____
- ❑ pulmonary emboli
- ❑ pacemaker
- ❑ heart disease
- ❑ angina
- ❑ chronic congestive heart failure
- ❑ varicose veins
- ❑ gout
- ❑ family history:_____

**Neurological**
- ❑ alzheimer's disease
- ❑ cerebral palsy
- ❑ dementia
- ❑ multiple sclerosis
- ❑ epilepsy
- ❑ paralysis
- ❑ vertigo
- ❑ epstein-barr syndrome
- ❑ brain injury: _____
- ❑ any loss of sensation, where?

  _____
- ❑ family history:_____

**Infectious Conditions**
- ❑ hepatitis
- ❑ herpes
- ❑ human immune virus
- ❑ auto-immune deficiency syndrome
- ❑ infectious mononucleosis
- ❑ mumps
- ❑ tuberculosis
- ❑ other:_____

**Respiratory**
- ❑ chronic cough
- ❑ fluid in lungs
- ❑ shortness of breath
- ❑ bronchitis
- ❑ asthma
- ❑ emphysema
- ❑ pneumonia
- ❑ sinus problems
- ❑ family history:_____

**Gastrointestinal**
- ❑ chrohn's disease
- ❑ colitis
- ❑ gastroenteritis
- ❑ constipation
- ❑ diarrhea
- ❑ diverticulitis
- ❑ heartburn
- ❑ ileitis
- ❑ ulcers
- ❑ irritable bowel syndrome
- ❑ family history:_____

**Skin**
- ❑ eczema
- ❑ psoriasis
- ❑ athletes foot
- ❑ bruise easily
- ❑ other skin conditions, please specify

  _____

**Headache**
- ❑ tension
- ❑ migraines or cluster:_____
- ❑ tooth/jaw/ear pain:_____
- ❑ other:_____

**Other Conditions**
- ❑ diabetes
  onset and type:_____
- ❑ allergies/hypersentivities:
  (❑anaphylaxis;❑skin irritations)

  _____
- ❑ cancer/type/treatment:_____

  _____

  _____
- ❑ family history of cancer
- ❑ arthritis/type:_____
- ❑ family history/type:_____
- ❑ vision loss/use of corrective lenses
- ❑ hearing loss
- ❑ fibromyalgia
- ❑ haemophilia
- ❑ sudden weight loss/gain
- ❑ liver issues
- ❑ bladder/kidney issues:_____

  _____
- ❑ osteopenia/osteoporosis
- ❑ any form of mental illness, please specify:_____

  _____
- ❑ other:_____

**Accident/Injury**
❑ Car ❑ Work Related ❑ Head Injury
Date(s): _____

_____
Physical Limitations/Symptoms:

_____

_____

_____

_____

_____

Please continue on the next page

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**Women**

- ❑ pregnant/ due date: MM / DD / YY
- ❑ gynecological conditions:_____
- ❑ breast pain
  - cysts
  - breast lift (date): MM / DD / YY
  - breast augmentation (date): MM / DD / YY
  - breast reduction (date): MM / DD / YY

**Current Medications and Supplements**

_____
_____
_____
_____

**Surgery**

type(s): _____
_____
_____
date(s) MM / DD / YY _____
_____
_____
_____

- ❑ **Present involvement in other Health Care: Yes/No**

If yes specify: _____
_____

- ❑ **Pins/ Wires/ Prosthetics:** _____
- ❑ **Medical Alert Bracelet** (specify condition/allergy)_____

_____

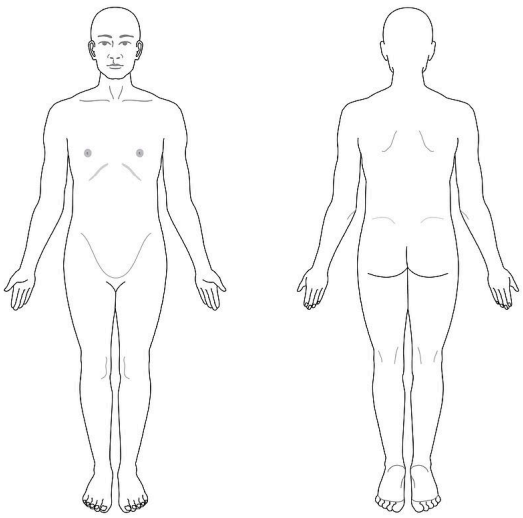
**Lifestyle Consideration**

- ❑ regular exercise (type, intensity, frequency):_____
- ❑ eating habits and/or dietary restrictions:_____
- ❑ water intake:_____

Please check if you use any of the following on a regular basis: ❑ cigarettes ❑ alcohol or drugs

**Soft Tissue/Joint Issues**

**Pain Diagram**



Use symbols below to indicate the type and location of your sensations right now.

KEY:

XXX= ache ///= burning OOO= numbness

SSS= stabbing +++= pins & needles

***= other (specify)_____

Specify if you have any past or present issues in these areas

| | Past | Present |
|---|---|---|
| ❑ neck | _____ | _____ |
| ❑ shoulder | _____ | _____ |
| ❑ upper back | _____ | _____ |
| ❑ mid back | _____ | _____ |
| ❑ low back | _____ | _____ |
| ❑ arms | _____ | _____ |
| ❑ chest | _____ | _____ |
| ❑ legs | _____ | _____ |
| ❑ knees | _____ | _____ |
| ❑ hips | _____ | _____ |
| ❑ other | _____ | _____ |

I have read the above information and have stated all my previous and current medical conditions. I take it upon myself to update the massage therapist regarding any changes in my condition. I understand that all massage treatments will be discussed and planned with the massage therapist, and will require my informed consent. **I understand that there is a 24 hour cancellation policy and agree to pay the missed appointment fee if I cancel with less than 24 hour before my appointment time. I understand that I am responsible to pay for the time I reserved with the therapist, regardless of the time I arrive and am ready for my appointment.**

**Signature: _____ Date: _____**

**Updated**

Date: _____ Client Signature: _____

Date: _____ Client Signature: _____

Date: _____ Client Signature: _____