Health History Form

The information requested below will assist 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…….

Address…….

…….Phone……

Email……

Date of Birth…….Occupation……

Have you received massage therapy before Yes / No

Did your healthcare 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	Yes / No	low blood pressure	Yes / No
chronic congestive heart failure	Yes / No	heart attack	Yes / No
phlebitis/varicose veins	Yes / No	stroke/CVA	Yes / No
pacemaker or similar device	Yes / No	heart disease	Yes / No

is there a family history of any of the above Yes / No

Respiratory

chronic cough	Yes / No	bronchitis	Yes / No	asthma	Yes / No
shortness of breath	Yes / No	emphysema	Yes / No		

is there a family history of any of the above Yes / No

Infections

hepatitis	Yes / No	TB	Yes / No	herpes	Yes / No

Other Conditions
loss of sensations, where …….
diabetes, onset:.....
allergies, hypersensitivity to what and type of reaction……
cancer, where……...
skin conditions, what……..
epilepsy Yes / No arthritis Yes / No Family history of arthritis Yes / No

Head/Neck
history of headaches Yes / No history of migraines Yes / No vision problems Yes / No
vision loss Yes / No ear problems Yes / No hearing loss Yes / No

Women
Pregnant, due…….. gynaecological conditions, what…….

Overall, how is your general health…….

Primary care physician name and address……..

……

Current medications and conditions they treat……... …...

……

Are you currently receiving treatment from another healthcare professional and if “yes” for what

……

Surgeries (dates and nature) …….

Injuries (dates and nature) …….

Do you have any other health conditions (e.g. digestive conditions, haemophilia, osteoporosis, mental illness)? If yes what …….

Do you have any internal pins, wires, artificial joints or special equipment? If yes what and where

…….

What is the reason you are seeking massage therapy? Please indicate location of any tissue or joint discomfort

……..

Signature……. Date……...