



Massage Therapy Health History

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 us know. You will also be asked to update your health history on a yearly basis. All information gathered for this treatment and during the treatment is strictly confidential, except as required by law. You will be asked to provide written authorization for release of any information.

Name: _____ Date: _____

Address: _____ Apt # _____ City/Prov _____ Postal code _____

Telephone: Home: _____ Cell: _____ Work: _____

Email: _____ Can we add you to our seasonal mailing list? Yes ___ No ___

Do you prefer to be contacted by phone _____ email _____ or either _____

Date of birth: _____ Occupation: _____

Have you received massage therapy before? Yes ___ No ___

What is the reason you are seeking massage therapy? _____

Did a health care provider refer you for massage therapy? Yes ___ No ___

If yes, please provide their name and address _____

How did you hear of this clinic? _____

Please indicate conditions you are experiencing or have experienced:

Soft Tissue/Joint Discomfort:

- Neck
- History of headaches: Type: _____
- History of migraines: Triggers, if known _____
- Back pain: Low ___ Mid ___ Upper ___
- Shoulders
- Arms / Hands
- Legs / Knees
- Arthritis: Where: _____ Is there a family history of arthritis? Yes ___ No ___
- Other: _____
Eg. Tendinitis/Bursitis/Scoliosis/Fracture/Sprain/Strain/Thoracic Outlet Syndrome/Carpal Tunnel Syndrome

Cardiovascular:

- High blood pressure
- Low blood pressure
- Chronic congestive heart failure
- Heart attack Date: _____
- Stroke / CVA (Cerebrovascular Accident) Date: _____
- Pacemaker or similar device
- Phlebitis / Varicose veins
- Edema or swelling
- Other: _____

Is there a family history of any of the above? Yes ___ No ___ If yes, please specify _____

Respiratory:

- Chronic cough
- Asthma
- Shortness of breath
- Emphysema
- Bronchitis

Is there a family history of any of the above? Yes ___ No ___ If yes, please specify _____

Nervous System:

- Loss of sensation _____
- Altered sensation (eg. pins and needles) _____
- Epilepsy
- Sciatica

Skin:

- Psoriasis _____
- Eczema _____
- Contact Dermatitis
- Sensitive Skin

Digestive:

- Irritable Bowel Syndrome
- Constipation
- Other: _____

Women:

- Pregnant: Due date: _____
- Recent birth _____
- Menopause
- Other: _____

Other Medical Conditions:

- Cancer: Type: _____
- Diabetes
- Allergies / Hypersensitivities _____ Type of reaction _____
- Vision problems / Vision Loss _____
- Hearing problems / Hearing Loss _____ Ear Problems _____
- Mental Illness
- Hemophilia
- Hepatitis
- TB
- HIV
- Herpes
- Other: _____

Overall, how is your general health? _____

Current medications and conditions treated: _____

Recent Surgeries: _____

Past injuries and accidents: _____

Do you have any artificial joints, internal pins/wires or special equipment? _____

Primary Care Physician; _____ Address: _____

Are you currently receiving treatment from another health care professional? (eg. Chiropractor, Naturopath, Acupuncture, Physiotherapy)

Emergency Contact: Name: _____ Phone number: _____

CLIENT'S CONSENT TO TREATMENT

I understand that I have the right to ask questions about my treatment. If at any time I feel uncomfortable, I can ask the therapist to stop or alter the treatment or clarify the reason for a therapeutic technique being used.

Date: _____ Signature: _____

Update 1 _____ Update 2 _____ Update 3 _____ Update 4 _____