

## HEALTH HISTORY FORM

For your information

An accurate health history is important to ensure that it is safe for you to receive massage therapy 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. You will be asked to provide written authorization for release of any information.

Name: \_\_\_\_\_ Date: \_\_\_\_\_

Address: \_\_\_\_\_ P. Code: \_\_\_\_\_

Telephone: \_\_\_\_\_  
home work cell

Where did you hear about the massage therapy clinic? \_\_\_\_\_

### Please check or fill in the appropriate information

What is your primary complaint? \_\_\_\_\_

#### Head/Neck

- headaches
- migraines
- sinus problems
- vision problems
- contact lenses
- glasses
- hearing loss

#### Cardiovascular

- high blood pressure
- low blood pressure
- CCHF
- heart disease
- heart attack
- stroke /CVA
- poor circulation
- phlebitis
- varicose veins

#### Respiratory

- chronic cough
- shortness of breath
- smoke \_\_\_\_\_
- bronchitis
- asthma
- emphysema

#### Muscles / Joints

- neck \_\_\_\_\_
- low back \_\_\_\_\_
- mid back \_\_\_\_\_
- upper back \_\_\_\_\_
- shoulders \_\_\_\_\_
- arm L/R \_\_\_\_\_
- leg L/R \_\_\_\_\_
- knee L/R \_\_\_\_\_
- other \_\_\_\_\_

#### Digestive/Uro-genital

- difficult digestion
- constipation
- liver / gall bladder
- kidney / bladder
- diabetes onset \_\_\_\_\_

#### Other Conditions

- epilepsy
- allergies \_\_\_\_\_
- colds
- insomnia
- cancer \_\_\_\_\_
- arthritis \_\_\_\_\_
- hepatitis \_\_\_\_\_
- TB
- HIV

#### Women

- menstrual problems
- pregnant due \_\_\_\_\_
- menopausal symptoms

#### Skin

- skin conditions  
type \_\_\_\_\_
- bruise easily

#### Exercise / Sport

- regular exercise  
type \_\_\_\_\_  
times per week \_\_\_\_
- specific training
- chronic pain / injury  
related to activity
- acute pain / injury  
related to activity

#### Surgery

Types (s): \_\_\_\_\_

Date(s): \_\_\_\_\_

Turn page over

**Recent Injuries:**

types (s): \_\_\_\_\_

date(s): \_\_\_\_\_

**Car accidents:**

yes / date(s): \_\_\_\_\_

- injuries sustained
- no injuries sustained

**Chiropractic:**

past date: \_\_\_\_\_

current

**Current Medication(s):**

types (s): \_\_\_\_\_

date(s): \_\_\_\_\_

**Physiotherapy:**

past date: \_\_\_\_\_

current

**Fracture(s):**

yes where \_\_\_\_\_

pins / plates / screws?

**Previous Massage Experience:** no yes when \_\_\_\_\_ where \_\_\_\_\_

**Primary Care Physician:** \_\_\_\_\_

Address: \_\_\_\_\_ Tel: \_\_\_\_\_

SIGNATURE: \_\_\_\_\_ DATE: \_\_\_\_\_

FOR OFFICE USE ONLY

Initial Assessment

Health History Update: \_\_\_\_\_

Therapist's notes:

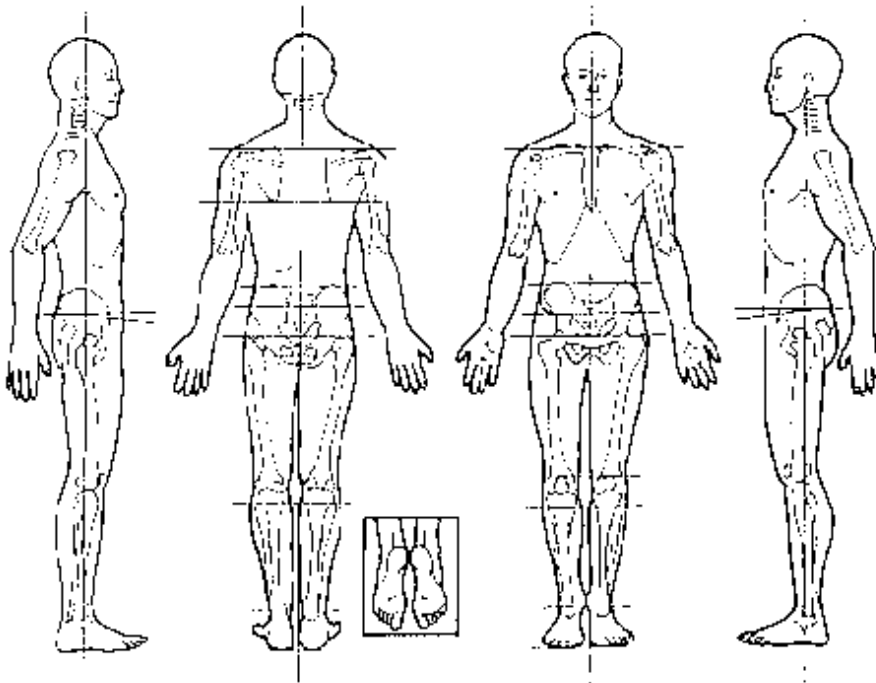
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GAIT

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R.O.M.

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TESTS.

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OTHER

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