Health History Form

FYI: an accurate health history ensures that it is safe for you to receive a massage treatment, and helps the therapist determine a proper treatment plan. When your health status changes in the future, please let us know. All information gathered on this form is confidential. Your written authorization is legally required before any of this information can be released.

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Client Name:

Personal Information

Name: ______________________ Date: ____________

Address: ______________________ City: ____________ Postal Code: ________

Home Phone: ____________ Work Phone: ____________ Occupation: ____________

Date of Birth: ____________ Email: ______________ Height: _____ Weight: _____

Doctor: ______________________ Phone: ____________ May I contact? ☐Yes ☐No

Emergency Contact Name: ______________________ Phone: ______________

Have you had a massage before? ☐Yes ☐No For relaxation or other reason?: ______________

Current Medications: ______________________

Previous Major Illnesses, Operations: ______________________

Accidents (please give dates): ______________________

____

Other Medical Conditions (e.g. hemophilia, diabetes): ______________________

Family history (major illnesses, operations): ______________________

Please indicate all conditions you have experienced. Mark C for current or P for past.

Joint/Soft Tissue Discomfort:

__ Arms
__ Upper Back
__ Mid Back
__ Lower Back
__ Degenerative Discs
__ Feet
__ Hands
__ Hips
__ Jaw
__ Knees
__ Legs
__ Neck
__ Osteo Arthritis
__ Rheumatoid Arthritis
__ SciaticaLimitation of Movement
__ Shoulders
in which joints: __________
Other ______________

Skin:

__Rashes
__Itching
__Bruise Easily
__Dryness
__Boils
Other ______________

General Symptoms:

__ Fainting
__ Dizziness
__ Loss of Sleep
__ Fatigue
__ Nervousness
__ Sudden Weight Loss/Gain
__ Numbness
__ Tingling
__ Paralysis
__ Headaches (Tension)
__ Migraines

Cardiovascular:

__ High Blood Pressure
__ Low Blood Pressure
__ Coronary Heart Disease
__ Heart Attack
__ Phlebitis
__ Stroke / CVA
__ Pacemaker
__ Heart Murmur
__ Palpitations
__ Varicose Veins
__ Swelling of the Ankles
__ Poor Circulation

Infectious:

__ Hepatitis
__ Tuberculosis
__ Human Immunodeficiency Virus (HIV)
__ Herpes
__ Cold
__ Flu
__ Athlete's Foot
__ Warts
Other ______________

Digestive:

__ Poor Appetite
__ Belching/Gas
__ Constipation
__ Diarrhea
__ Nausea
__ Ulcer
__ Vomiting

Eye, Ear, Nose, Throat:

__ Allergies
__ Frequent Colds
__ Glasses or Contacts
__ Hearing Aid
__ Hearing Loss
__ Sinus Infection
__ Swollen Glands

(continued on reverse)

Please indicate all conditions you have experienced. Mark C for current or P for past.

Reproductive:

__ Pregnant
due date _______________
__ Painul Menstruation
__ Heavy Flow
__ Irregular Cycle
__ Swollen Breasts
__ Menopausal
__ Pre-menopausal
__ Post-menopausal
__ Birth control
type _________________

Respiratory:

__ Chronic Cough
__ Bronchitis
__ Asthma
__ Hay Fever
__ Difficulty Breathing
__ Smoking
__ Emphysema
__ Pneumonia

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Lifestyle Questions

Regular eating habits ☐Yes ☐No
Do you take vitamins: ☐Yes ☐No
Type: ______________________________
Frequency: _________________________
Regular exercise ☐Yes ☐No
Type: ______________________________
Frequency: _________________________

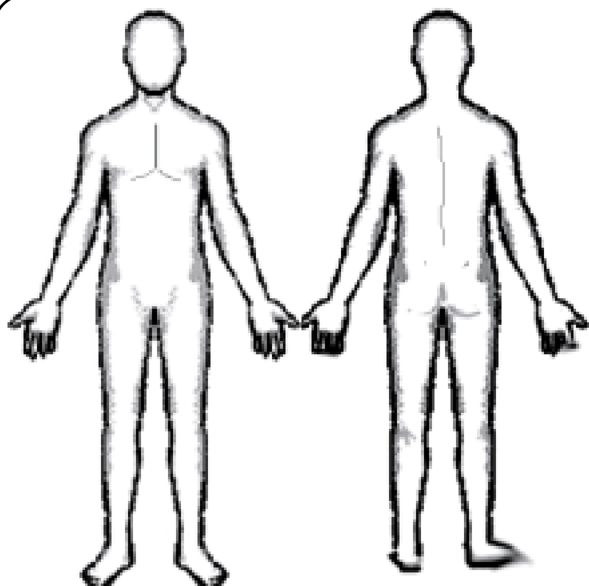
Energy Level: ☐High ☐Average ☐Low
Do you suffer from stress? ☐Yes ☐No
Type: ______________________________
Do you use a computer? ☐Yes ☐No
How many hours per day: ______________

Please read carefully, and sign.

I attest that the information I have provided is true and complete to the best of my knowledge.
I understand the information I have provided on this form is confidential and will not be released without my written consent.
I consent to therapeutic massage treatment by the above named massage therapist.
I also understand that I am responsible for any charges incurred in the course of my treatment.
I understand that 24 hours notice is required to reschedule all future appointments, or full charges will apply.

____ signature

________________________________ today's date



circle any focal areas

This area to be filled out by the therapist.

Treating Therapist: ____________________________

Duration of Massage: ______________ Cost: ________

Techniques Used: ______________________________

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____

Comments: ___________________________________

____

Self Care Recommendations: ____________________

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