URBAN HEALTH GROUP

MASSAGE THERAPY HEALTH HISTORY FORM

Name: ______________________________ Birth Date: ____________________ (DD/MM/YYYY)

Address: ______________________________________ Postal Code: __________

Phone #: (home)______________ (work)______________ Occupation: ______________

Email Address: ______________ Primary Complaint: ____________________

Family Physician: ____________________ Phone #: ____________________

Were you referred? ☐ YES ☐ NO

Please indicate all current and past conditions

Muscles/Joints/Nerves
- ☐ Headaches
- ☐ Head Trauma/Concussion
- ☐ Neck Pain/Injury
- ☐ Whiplash
- ☐ Back Pain ___________
- ☐ Shoulder Pain/Injury
- ☐ Arm Pain/Weakness/Tingling
- ☐ Degenerative Discs
- ☐ Scoliosis
- ☐ Sciatic/Hip Pain
- ☐ Leg Pain/Weakness/Tingling
- ☐ Knee Pain/Injury
- ☐ Foot Pain/Injury
- ☐ Osteo/Rheumatoid Arthritis
- ☐ Tendonitis/Bursitis/Fibrositis
- ☐ Osteoporosis
- ☐ Fractures/Dislocations
- ☐ Stiff Swollen Joints
- ☐ Fibromyalgia
- ☐ Multiple Sclerosis
- ☐ Epilepsy
- ☐ Shingles
- ☐ Nervousness/Depression

Respiratory
- ☐ Asthma/Bronchitis
- ☐ Chronic Cough
- ☐ Shortness of breath
- ☐ Allergies/Sinus problems
- ☐ Emphysema

Contagious Diseases
- ☐ HIV/AIDS
- ☐ Hepatitis ☐ A ☐ B ☐ C

Cardiovascular
- ☐ High ☐ Low Blood Pressure
- ☐ Heart Attack/Stroke
- ☐ Chest Pain/Angina
- ☐ Varicose Veins/Phlebitis
- ☐ Cold Hands/Feet
- ☐ Poor Healing/Bruising
- ☐ Diabetes
- ☐ Anemia
- ☐ Fatigue

Eyes/Ears/Throat
- ☐ Dizziness
- ☐ Pain behind the eyes
- ☐ Blurred vision
- ☐ Ringing in the ears
- ☐ Recent dental work
- ☐ TMJ/Jaw cracking
- ☐ Clenching/Grinding teeth

Gastrointestinal
- ☐ Nausea
- ☐ Constipation/Diarrhea
- ☐ Ulcers
- ☐ Hiatus hernia
- ☐ Irritable bowel syndrome
- ☐ Crohn’s disease
- ☐ Diverticulitis
- ☐ Hypoglydemia

Gentlo-urinary
- ☐ Painful/Frequent urination
- ☐ Kidney/Gall stones
- ☐ Bladder infection

Gynecological
- ☐ Currently Pregnant
- ☐ PMS
- ☐ Menopause
- ☐ Fibrocystic breasts

Skin
- ☐ Sensitive
- ☐ Rash/Eruption
- ☐ Cold sores

Other Surgeries
- ☐ Abdominal
- ☐ Heart/Chest
- ☐ Pelvic
- ☐ Vascular
- ☐ Other ___________

Cancer
- ☐ Breast
- ☐ Lung
- ☐ Colon
- ☐ Prostate
- ☐ Skin
- ☐ Other ___________

Lifestyle
- ☐ Exercise
  - ☐ Regular ☐ Seldom
- ☐ Sleeping pattern
  - ☐ Regular ☐ Irregular
- ☐ High work ☐ Family stress

Are there any prominent diseases in your family? (e.g. heart disease, cancer, diabetes): ____________________

____

List all current medications, including aspirin or other over the counter pharmaceuticals ____________________

____

List any pins, wires, screws, plates from previous surgeries ____

Have you received Massage Therapy before? ☐ YES ☐ NO If YES, how often? ________________________

I have received: ☐ Chiropractic ☐ Physiotherapy ☐ Acupuncture ☐ Other ____________________________

What brings you for a massage? ☐ Relaxation ☐ Pain ☐ Injury ☐ Stress ☐ Other ____________________

What have you tried for relief? ☐ Hot ☐ Cold ☐ Exercise ☐ Other ________________________________

What area of the body would you like your treatment to be focused? _________________________________

____

Are there any areas that you prefer NOT to be treated? ____

Are you currently being treated by another health care profession for a specific condition? If yes, please explain:

____

On behalf of Urban Health Group and part of our profession's on-going commitment to provide quality care, it is essential that you fully understand and are fully aware of your rights, treatment and policies.

I fully understand the information given on this form is absolutely confidential and may be released to other health care professionals or legal representative ONLY with my written consent.

In regards to treatment, I have the right to ask questions, alter or stop treatment at any time, ensuring my absolute comfort and care. The Registered Massage Therapist also has the right to terminate or refuse treatment if there is a reasonable and "just" cause.

I have read and fully understand all the information included in this consent. I confirm that I am capable of consenting to the treatment.

Client signature ____________________________________ **Date**____________________________

Updated	**Date:**	**Date:**	**Date:**	**Date:**	**Date:**
Client Signature					