Health History Form

***Please note that all information is confidential.

Personal Information

Name:_____ Male/Female D.O.B.:_____
Complete Address:_____
Telephone #'s - Home:_____ Work:_____
Occupation:_____ Email:_____

Physician's Name:_____ Telephone#:_____
Address:_____

Medications & Reason for use:
_____
_____
_____
_____

Other Treatments: ___Chiropractic ___Physiotherapy ___Occupational Therapy
___Alternative Therapy ___Other (Please specify)_____

Current Health Status

Primary Complaint:
_____
_____

List Problem Areas:

___ Spine	___ SI joint	___ Muscle Weakness
___ Shoulder	___ Hip	___ Muscle Soreness
___ Elbow	___ Knee	
___ Wrist	___ Ankle	
___ Hand	___ Foot	

Lifestyle: ___ Exercise Regularly ___ Alcohol/Drugs ___ Smoke ___ Caffeine

Previous Injuries

Injury	Date	Treatment Received
_____	_____	_____
_____	_____	_____
_____	_____	_____

Previous Surgeries

Surgery	Date	Treatment Received
_____	_____	_____
_____	_____	_____
_____	_____	_____

___ Pacemaker ___ Cosmetic Implants ___ Pins/Plates/Needles (Location :_____)

Medical History (Please complete to the best of your knowledge)

Cardiovascular:
___ Hemophilia
___ C.V.A. (Stroke)
___ Myocardial infarction (heart attack)
___ High blood pressure
___ Low blood pressure
___ Congestive heart failure
___ Buerger's disease
___ Raynaud's disease
___ Dizziness
___ Chest pain
___ Varicose veins
___ Deep vein thrombosis

Respiratory:
___ Emphysema
___ Asthma
___ Cystic Fibrosis
___ Bronchitis (Acute/Chronic)
___ Chronic cough
___ Breathing difficulty

Neurological:
___ Epilepsy
___ Multiple Sclerosis
___ Parkinson's
___ Cerebral Palsy
___ Other (please specify) _____
_____
___ Carpal Tunnel Syndrome
___ Thoracic outlet syndrome
___ Bell's Palsy
___ Neuritis/Neuralgia/Causalgia

Muscles/Joints:
___ Osteoarthritis
___ Rheumatoid Arthritis
___ Ankylosis Spondylitis
___ Osteoporosis
___ Other (please specify) _____
_____

Allergies:
___ Anaphylactic shock
___ General allergies (please specify) _____
_____

Gastrointestinal:
___ Crohn's disease
___ Ulcerative colitis
___ chronic abdominal discomfort
___ prolonged constipation
___ prolonged diarrhea
___ pelvic inflammatory disease

Other:
___ Diabetes
___ Cancer
___ HIV/AIDS
___ Hearing/Vision Loss
___ Hepatitis
___ Tuberculosis
___ skin irritation (eczema/psoriasis)
___ fibromyalgia
___ pregnancy

CONSENT TO TREATMENT (please sign in presence of therapist)

I _____, consent to massage therapy as described by the massage therapist. I also verify that the information given on this form is true and accurately reflects my past and present health status.

Signature:_____ Date:_____