Health History Form

Name: _____ Phone: _____

Address: _____

Occupation: _____ Date of Birth: _____

Email address: _____

Have you received Massage before? Yes ☐ No ☐ When? _____

Did you receive a referral for massage? Yes ☐ No ☐

Please list the source of referral: _____

Family Doctor: _____ Address: _____

Please list any condition you are experiencing or have experienced in the past:

☐ high blood pressure
☐ Low blood pressure
☐ varicose vein/phlebitis
☐ heart problem : _____
☐ stroke/CVA
☐ artificial heart valve/pacemaker*

☐ hepatitis, type: _____
☐ Herpes
☐ skin condition: _____
☐ TB
☐ HIV

☐ loss of sensation, where: _____
☐ tingling, shooting pain, where
☐ tingling, shooting pain, where
☐ sciatica R/L

☐ Asthma, onset: _____
☐ Bronchitis, onset: _____
☐ Emphysema, onset: _____
☐ Shortness of breath

☐ diabetes, type I or II
☐ bursitis, where: _____
☐ epilepsy
☐ fibromyalgia
☐ arthritis, RA or OA, onset
☐ family history of arthritis
☐ internal wires, pins, or artificial joints or special equipment

What: _____
Where: _____

☐ Allergies, to what: _____
☐ Tendinitis, where: _____
☐ Cancer
☐ Degenerative disc disease
☐ Pregnancy, due date:* _____
☐ Gynaecological condition
☐ Migraine
☐ Headache
☐ And other condition not mentioned:

_____

*information required for acupuncture technique

(The information on this form will assist in establishing appropriate treatment and will be kept confidentially unless otherwise allowed or required by law as per my privacy policy, you may see the privacy policy at any time)

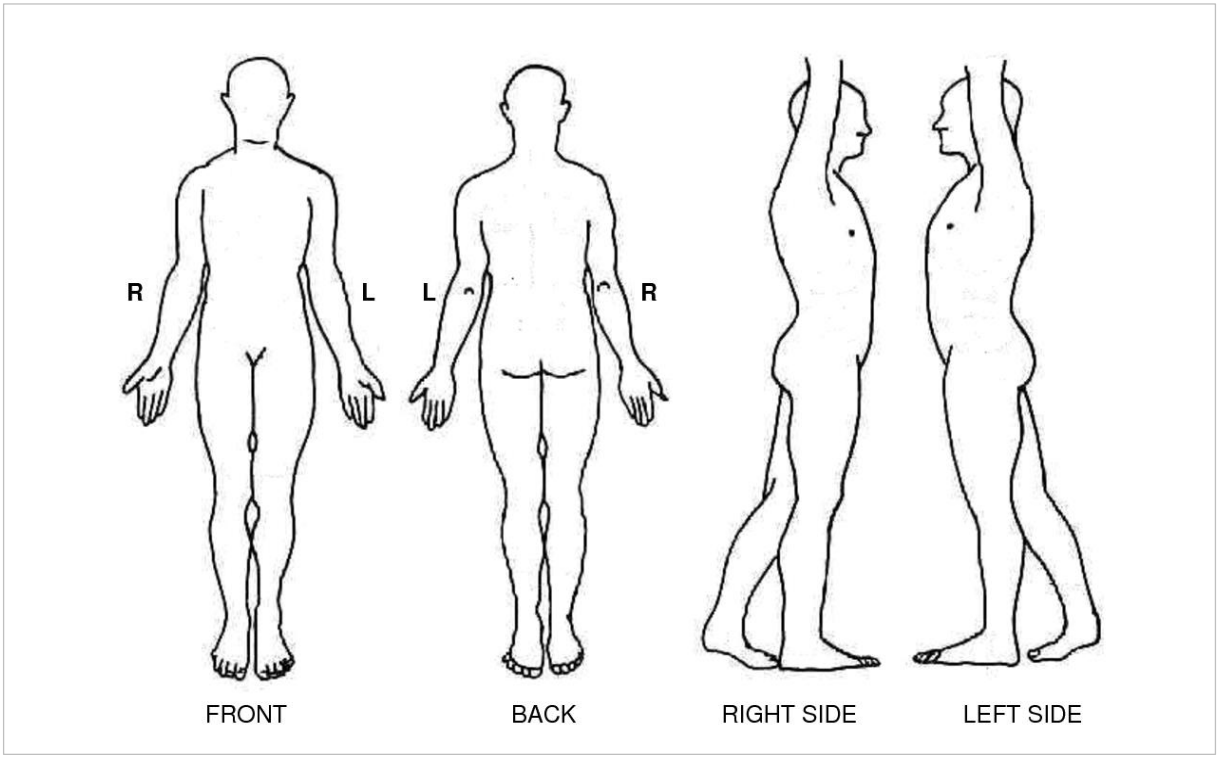
What is your Primary Complaint? _____

Current General Health: Very Healthy ☐ Good ☐ Fair ☐ Poor ☐

Current Involvement of treatment with other Health Care Providers?

Please list **all medication** and reason for use:	Please list previous **injuries or surgeries**:

Please indicate your pain on the picture below:



I verify the information on this form is represents my past and current health status. I hereby consent for my therapist to treat me with massage therapy for the above noted purposes including such assessments, examinations and techniques, which may be recommended, by my therapist. I acknowledge that the therapist is not a physician and does not diagnose illness or disease or any other physical or mental disorder. I clearly understand that massage therapy is not a substitute for medical examination.

Signature: Date:

Date of initial Health History:	
Date of Update 1:	
Date of Update 2:	
Date of Update 3:	
Date of Update 4:	