Confidential Health History

The information below will assist us in treating you safely. Feel free to ask any questions about the information being requested. Please note that all information provided will be kept confidential unless allowed or required by law. Your written permission is required to release any information.

Name:_____
Date of Birth: _____
Address:_____
City:_____Prov:_____Postal Code:_____
Phone(H):_____(W):_____
Cellphone: _____E-mail: _____
Current Date:_____

Occupation: _____
Family Physician:_____
Address:_____
Have you ever seen a Massage Therapist? _____
Did a health care provider refer you for massage? _____
If so, please provide their name and address:
_____

Have you been diagnosed with, or have you ever experienced any of the following?

Circulatory/Respiratory
___ Chronic congestive heart failure
___ Heart Disease
___ Heart Attack
___ Pacemaker
___ High blood pressure
___ Low blood pressure
___ Varicose veins/Phlebitis
___ Deep vein thrombosis
___ Stroke/CVA
___ Chronic cough
___ Bronchitis
___ Asthma
___ Emphysema
___ Shortness of breath

Is there a family history of any of the above? □ No □ Yes

Nervous system
___ Epilepsy
___ Multiple sclerosis
___ Cerebral palsy
___ Sciatica
___ Carpal tunnel syndrome

Musculoskeletal
___ Scoliosis
___ Bone or joint disease
___ Arthritis
___ Joint instability
___ Tendinitis
___ Fractured bones
___ Jaw pain (TMJ)
___ Whiplash

Is there a family history of arthritis?
□ No □ Yes

Infections
___ hepatitis
___ contagious skin conditions
___ TB
___ HIV
___ herpes

Head & Neck
___ History of headaches
___ History of migraines
___ Vision problems/loss
___ Hearing problems/loss

Other Conditions
Loss of sensation, where?
_____
Skin condition, what?
_____
Allergies/Sensitivities, to what?
_____
Diabetes, onset?
_____
Cancer, where?
_____

Women
Pregnant? Due: _____
Gynaecological conditions, what?
_____

Please list any other conditions not listed & provide details as needed.
_____
_____
_____

Overall, how is your general health?
_____

Current medications & condition it treats: _____
_____

Are you currently receiving treatment from another health care professional? □ No □ Yes
If yes, for what? _____

Surgeries – date and type: _____
_____

Injuries – date and details: _____
_____

Do you have any internal pins, wires, artificial joints or special equipment? If so, provide details:
_____

What is the reason you are seeking massage therapy? Please include the location of any joint or tissue discomfort.
_____
_____
_____
_____
_____