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.

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
- __ Sciatica
- __ Shoulders
- __ Limitation of Movement

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)

Client Name:

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

Reproductive:
__ Pregnant
due date ___________________________
__ Painful Menstruation
__ Heavy Flow
__ Irregular Cycle
__ Swollen Breasts
__ Menopausal
__ Pre-menopausal

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

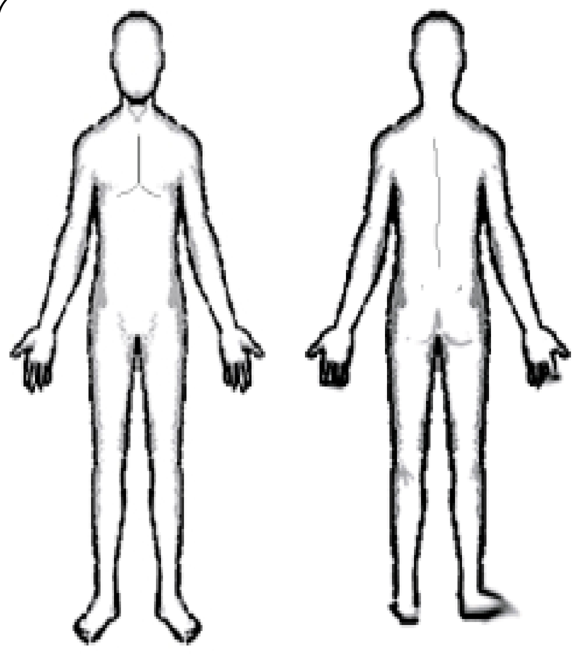
Lifestyle Questions

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.

Duration of Massage: ______________ Cost: _______

Techniques Used: ______________________________

____

____

Comments: ___________________________________

____

Self Care Recommendations: ____________________

____

__ Post-menopausal
__ Birth control
type ____

Client Name:

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