Massage Therapy

Health History Form

The information request below will assist in treating you safely.
Feel free to ask any questions about the information being requested.

Name:______________________________ Date of Birth: ______________________________
Address: ________________________ Postal Code: ________________________________
Telephone #: (Home) __________________ (Work)__________________ (Cell)__________________
Email Address: ______________________________Occupation:______________________________
Emergency Contact: (Name) _________________ (Relationship) _______________ (Phone #) __________
Physician's Name: ______________________ Address: ____________________ Phone #: __________
How did you hear about us?____

Please indicate with a check mark, in the ☐ conditions that you are currently experiencing or have experienced and indicate in the △ conditions that are present within the family history

Cardiovascular

☐ △High Blood Pressure
☐ △ Low Blood Pressure
☐ △ Heart Attack
☐ △ Stroke/CVA
☐ △Chronic Congestive Heart Failure
☐ △ Varicose Veins
☐ △ Pacemaker

Respiratory

☐ △ Asthma
☐ △Bronchitis
☐ △ Emphysema
☐ △Chronic Cough
☐ △ Shortness of Breath
☐ △ Bruise easily
☐ △COPD

Contagious Diseases

☐ HIV/AIDS
☐ Hepatitis A/B/C
☐ Herpes/Cold Sores
☐ Tuberculosis (TB)
☐ Warts/Plantar Warts
Where:_________
☐ Athletes Foot

Lifestyle

Exercise
☐ Regular ☐ Seldom
Sleeping Pattern
☐Regular ☐ Irregular
☐ High Work/Family Stress

Head and Neck

☐ △Whiplash
☐ △ Head Trauma/Concussion
☐ △ Headaches
☐ △Migraines
☐ △Vision Problems
☐ △Ear Problems/Ringing

Muscles/Joints/Nerves

☐ Pain ☐ Injury
☐ Jaw/TMJ
☐ Neck
☐ Shoulder
☐ Arm ☐ Elbow ☐ Hand
☐ Back ☐ Upper ☐ Lower
☐ Hip
☐ Leg ☐ Knee ☐ Foot
☐ Fractures/Dislocations
Where: ___________
☐ Stiff/Swollen Joints
☐ Degenerative Disc Disease
☐ Scoliosis
☐ Osteoporosis
☐ △ Arthritis
☐ △Osteoarthritis
☐ △Rheumatoid
☐ △**Gout**
☐ Other: ___________
☐ Tendonitis/Bursitis/Fibrositis
☐ Fibromyalgia
☐ Multiple Sclerosis
☐ Shingles
☐ Nervousness/Depression/Fatigue

Gynecological

☐ Pregnant, Due Date:________
☐ Attempting Pregnancy________
☐ # of Previous Pregnancies: _____
☐ Complications/Miscarriages:_____
☐ Other Gynecological Conditions:
☐ PMS ☐ Menopause
☐ Endometriosis
☐ Other: _____________

Other

☐ Loss of Sensation
Where:___________
☐ △ Diabetes ☐ Type 1 ☐ Type 2
Onset: _________________________
☐ Epilepsy
Diagnosed: _____________________
☐ Surgeries - Type/Date/Symptoms
____
____
____
____
____
☐ △Cancer - Type/Date/ Diagnosed/ Treatment Received
____
____
____
☐ Skin Problems Type
____

Have you ever received massage therapy before? □Yes □No

Do you have any other medical conditions? (E.g. digestive conditions, hemophilia, osteoporosis, mental illness)
□Yes □No→ If yes what? ____

Are you on any Current Medications? □Yes □No
If yes, what conditions do they treat? ____

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

Do you have any internal pins, wires, artificial joints or special equipments? □Yes □No
What? ____
Where?____

What is your primary complaint for seeking massage therapy? ________________________________
Please include the location of any tissue or joint discomfort ________________________________

If there is any additional information relating to anything above or that you feel might be important/relevant please document it in the following area. ____
____

Please read and check off boxes as read and understood. If you have a question please ask your therapist about any concerns.

□ ***I understand that a cancellation policy is in effect. If the need arises to cancel an appointment, 24 hrs. notice must be given or a $50 fee may be applied.***

□ I understand that my initial visit will include completion of case history form and any necessary questions, blood pressure reading and orthopedic assessments, and that they will be updated yearly.

□ This is a therapeutic massage and any sexual remarks or advances will terminate the session and you will be liable for any payment of the schedule treatment.

□ I understand that all information gathered for this treatment remains confidential except as required or allowed by law or to facilitate assessment of treatment. I also understand that the therapist may discuss my case with peers who are under the same confidentially clause in order to provide the best treatment possible. No other personal information will be disclosed other than that which is directly associated with my care.

□ I understand that my personal contact information is used for scheduling appointments, reminder calls, follow ups, mailing newsletters, greeting cards or thank-you cards and for billing purposes. I also understand that I have the right to access the privacy policy for more details, which is available upon request.

□ I understand that if any third party requests my personal health information , I have the option to sign a consent of disclosure agreement before any information will be made available to them and only that to which I consent to will be made available except as required by law.

□ I have read and understood all information contained within this form. Being that massage should not be done under certain medical conditions, I affirm that I have answered all questions pertaining to medical conditions to the best of my knowledge.

I give my consent to continue with treatment by ________________________________RMT
Signature: ________________________________ Date: ________________

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Form updated on: __________
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