

## Massage Health History Form

Name: \_\_\_\_\_ Date: \_\_\_\_\_

Address: \_\_\_\_\_ Postal Code: \_\_\_\_\_

Phone: Home: \_\_\_\_\_ Work: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Email Address (for massage discounts) \_\_\_\_\_ AHC # \_\_\_\_\_

Occupation: \_\_\_\_\_ Activities: \_\_\_\_\_

Medical Doctor: \_\_\_\_\_ Chiropractor: \_\_\_\_\_ Naturopath: \_\_\_\_\_

Medications: \_\_\_\_\_ Allergies: \_\_\_\_\_

Previous Injuries/Surgeries: \_\_\_\_\_

History of Cancer: Y / N Type: \_\_\_\_\_ Has treatment been approved by your Dr? \_\_\_\_\_

HIV: Y / N Hepatitis: Y / N

Are you pregnant? Y / N Due Date: \_\_\_\_\_

Referred by: \_\_\_\_\_

### Current Health Condition

What is your present complaint?

\_\_\_\_\_

Do you know the cause?

\_\_\_\_\_

When do you experience this?

\_\_\_\_\_

(morning, evening, sleeping, during/after activity)

Describe symptoms:

\_\_\_\_\_

(throbbing, burning, dull, cramping, numbness, tingling, sharp, shooting)

Duration of symptoms:

\_\_\_\_\_

(constant, intermittent, brief)

What relieves?

\_\_\_\_\_

What aggravates?

\_\_\_\_\_

**Please check those which apply:**

- |  |   |  |
|--|---|--|
| <input type="checkbox"/> Morning stiffness         | <input type="checkbox"/> Headaches, Tension, Migraine | <input type="checkbox"/> Respiratory Infection         |
| <input type="checkbox"/> Painful/Swollen joints    | <input type="checkbox"/> Dizziness/Fainting           | <input type="checkbox"/> Asthma                        |
| <input type="checkbox"/> Crunching/Grinding Joints | <input type="checkbox"/> Ringing in Ears              | <input type="checkbox"/> Chest Pain                    |
| <input type="checkbox"/> Pins/Plates/Prosthesis    | <input type="checkbox"/> Jaw (TMJ) Pain               | <input type="checkbox"/> High/Low Blood Pressure       |
| <input type="checkbox"/> Bone Pain                 | <input type="checkbox"/> Fatigue                      | <input type="checkbox"/> Heart Attack                  |
| <input type="checkbox"/> Weakness                  | <input type="checkbox"/> Fibromyalgia                 | <input type="checkbox"/> Stroke                        |
| <input type="checkbox"/> Rheumatoid Arthritis      | <input type="checkbox"/> Eczema, Psoriasis            | <input type="checkbox"/> Varicose Veins                |
| <input type="checkbox"/> Osteoarthritis            | <input type="checkbox"/> Abdominal Pain               | <input type="checkbox"/> Deep Vein Thrombosis          |
| <input type="checkbox"/> Osteoporosis              | <input type="checkbox"/> Constipation/Diarrhea        | <input type="checkbox"/> Cold Hands/Feet               |
| <input type="checkbox"/> Diabetes Type I/II        | <input type="checkbox"/> Urinary Infection            | <input type="checkbox"/> Color Changes in Fingers/Toes |

Additional condition(s) not listed: \_\_\_\_\_

I declare the information on this form to be true and correct in all respects. I understand that the Massage Therapist will rely on the information given by me to provide safe treatment. If any information is not correct, I release the Massage Therapist from any and all claims arising out of any treatment provided. **Cancellation policy:** 24 hours notice is required for cancellation of appointments. As well, please be aware that in order to provide timely service to all of our clients, late arrival to an appointment will result in shorter treatment duration.

Client Name: (Please print) \_\_\_\_\_ Date: \_\_\_\_\_

Client Signature: \_\_\_\_\_