

# HEALTH HISTORY FORM

The information request 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 below will be kept confidentially unless allowed or required by law. Your written permission will be required to release any information.

Name: \_\_\_\_\_ Phone: \_\_\_\_\_

Address: \_\_\_\_\_ Email: \_\_\_\_\_

Occupation: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Have you received massage therapy before?  Yes  No

Did a health care practitioner refer you for massage therapy?  Yes  No

If yes, please provide their name and address: \_\_\_\_\_

## Please indicate conditions you are experiencing or have experienced:

### Cardiovascular

- high blood pressure
- low blood pressure
- chronic congestive heart failure
- heart attack
- phlebitis / varicose veins
- stroke/CVA
- pacemaker or similar device
- heart disease

is there a family history of any of the above?

Yes  No

### Respiratory

- chronic cough
- shortness of breath
- bronchitis
- asthma
- emphysema

is there a family history of any of the above?

Yes  No

### Infections

- hepatitis
- skin conditions
- TB
- HIV
- herpes

### Other Conditions

- loss of sensation, where? \_\_\_\_\_
- diabetes, onset: \_\_\_\_\_
- allergies/hypersensitivity, to what? \_\_\_\_\_
- type of reaction: \_\_\_\_\_
- epilepsy
- cancer, where? \_\_\_\_\_
- skin conditions, what? \_\_\_\_\_
- arthritis

is there a family history of arthritis?

Yes  No

### Head/Neck

- history of headaches
- history of migraines
- vision problems
- vision loss
- ear problems
- hearing loss

### Women

pregnant, due date: \_\_\_\_\_

gynecological conditions, what? \_\_\_\_\_

Overall, how is your general health?

\_\_\_\_\_

Primary Care Physician:

\_\_\_\_\_

Address:

\_\_\_\_\_

Current Medications: \_\_\_\_\_

condition(s) being treated: \_\_\_\_\_

Are you currently receiving treatment from another health care professional?

Yes  No

If yes, for what? \_\_\_\_\_

Surgery - date \_\_\_\_\_

nature: \_\_\_\_\_

Injury - date \_\_\_\_\_

nature: \_\_\_\_\_

Do you have any other medical conditions? (e.g. digestive conditions, hemophilia, osteoporosis, mental illness)

Yes  No

what? \_\_\_\_\_

Do you have any internal pins, wires, artificial joints or special equipment?

Yes  No

what? \_\_\_\_\_

where? \_\_\_\_\_

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

\_\_\_\_\_

Notes:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Date of initial health history: \_\_\_\_\_

Update 1: \_\_\_\_\_

Update 2: \_\_\_\_\_

Update 3: \_\_\_\_\_

Update 4: \_\_\_\_\_

## CONDITION INFORMATION

What is your primary complaint? \_\_\_\_\_

Can you describe it?  DULL  SHARP  SHOOTING  ACHY  NUMB  TINGLING  STIFF

Pain scale (1 being low; 10 being high): \_\_\_ /10

Does it radiate anywhere? \_\_\_\_\_

Does anything aggravate your symptoms? \_\_\_\_\_

Does anything relieve your symptoms? \_\_\_\_\_

When did your symptoms begin? \_\_\_\_\_

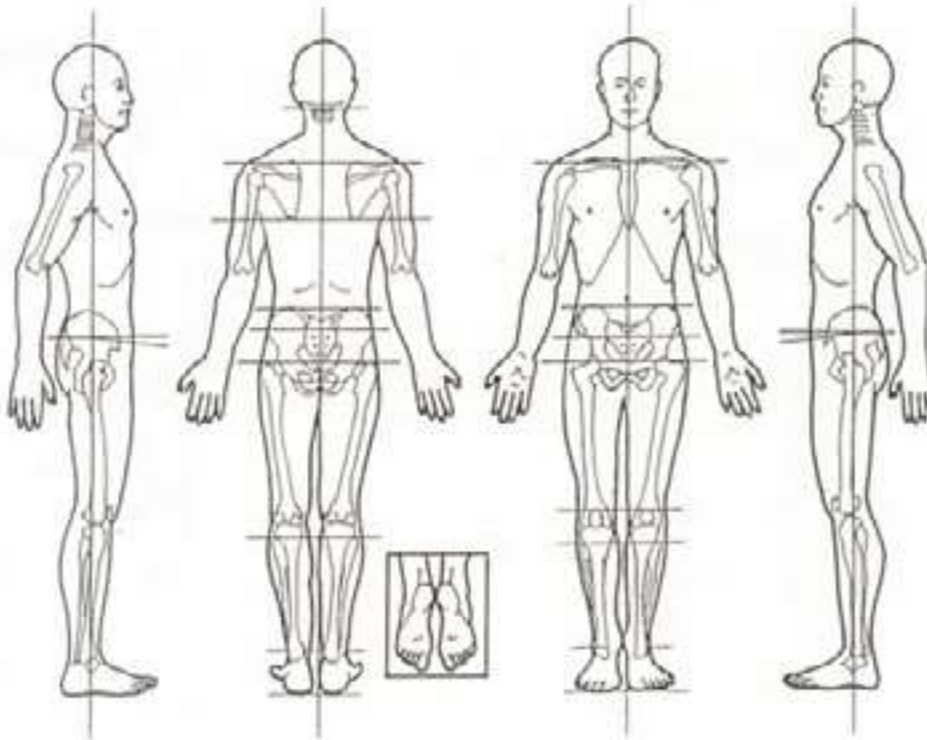
Have they changed and how? \_\_\_\_\_

Is this condition interfering with:  WORK  SLEEP  ACTIVITIES of DAILY LIVING

Please explain: \_\_\_\_\_

## ASSESSMENT

On the diagram, please indicate the areas that are causing you pain/discomfort with an ×



I, \_\_\_\_\_, have filled out this case history accurately and to the best of my ability.

All the information will be kept confidential between me and my Registered Massage Therapist. A written authorization will be obtained prior to the release of information. I also have the right to stop, change or modify the treatment at any time.

Signature \_\_\_\_\_ Date \_\_\_\_\_