Health History Form

The information requested 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:____ DOB:____________________
Address:____ Occupation:________________
Phone:________________ Alternate:________________ Email:______________________________
Primary Health Care Provider:________________________ Address:____________________

Have you received massage therapy before? Y N Other bodywork?________________________________
Were you referred by a health care practitioner? Y N If yes, their name?___________________________

Cardiovascular

☐ High Blood Pressure
☐ Low Blood Pressure
☐ Chronic Congestive Heart Failure
☐ Heart Disease
☐ Phlebitis/Varicose Veins
☐ Stroke/Cerebral Vascular
Accident date:__________________
Is there a family history of the above? Y N

Respiratory

☐ Chronic Cough
☐ Shortness of Breath
☐ Bronchitis
☐ Asthma
☐ Emphysema
☐ Lung Disease

Neuromuscular/Autoimmune

☐ Fibromyalgia
☐ Chronic Fatigue Syndrome
☐ Multiple Sclerosis
☐ Celiac/BS
☐ Diabetes Type? _____________
Onset: ________________________
Is there a family history of the above? Y N

Infections

☐ Hepatitis: type? ______________
☐ Tuberculosis
☐ Skin Conditions:
☐ Eczema ☐ Psoriasis
☐ Other____________________
☐ HIV
☐ Herpes/Cold Sores

Head/Neck

☐ History of Headaches
☐ History of Migraines
☐ Vision Loss
☐ Vision Problems _____________
☐ Hearing Loss
☐ Ear Problems _______________
☐ Balance problems/vertigo/dizziness
☐ Whiplash: date ______________

Women

☐ Pregnancy: due date
____

PLEASE SEE REVERSE FOR CONSENT FORM

☐ Other gynecological conditions

Other Conditions

☐ Loss of Sensation where?________
______________ Onset?__________
☐ Allergies/Hypersensitivity to what?
____

☐ Arthritis what type? ____________
Joints affected? __________________
Is there a family history of the above? Y N
☐ Epilepsy/Seizures
☐ Cancer _______________________
Date of Diagnosis: ________________
Lymph Nodes Removed? Y N
Where? ________________________
___________ How many? _________
☐ Are you currently undergoing treatment? Y N

Injury Date: _____________________
Nature: ________________________
____
Surgery Date: ____________________
Nature: ________________________
____
Current Medications: ______________
____
Conditions Treated: _______________
____

Are you currently receiving treatment from another health care practitioner? Y N

Do you have any other medial conditions (i.e. osteoporosis, mental health, digestive disorders, etc.)? ________________

____

Do you have any pins, wires, artificial joints or special equipment? Y N What?______________________________

____

Where?

____

What is the reason you are seeking massage therapy? ____

What aggravates your condition? ____

What physical activities do you engage in? ____

Overall, how is your general health? ____

Check areas of any joint or tissue discomfort:

☐ Head/Scalp ☐ Face ☐ Jaw ☐ Neck ☐ Shoulder ☐ Upper Back ☐ Mid Back ☐ Lower Back ☐ Tailbone ☐ Gluteals ☐ Thigh front ☐ Thick back ☐ Calf front ☐ Calf back ☐ Feet ☐ Hands ☐ Arms ☐ Chest ☐ Abdomen ☐ Groin

Intake for Pregnant Clients

Due Date: __________________ This is my ____ (1st, 2nd, etc.) pregnancy. This will be my ____ (1st, 2nd, etc.) birth.

Please check ☑ any conditions you currently experiencing, or ☒ conditions you have experienced in the past.

☐ Edema/Swelling ☐ Leg Cramps ☐ Nausea ☐ Fatigue ☐ Varicose Veins ☐ Multiple Birth ☐ Separation of the Rectus Abdominal muscles ☐ Separation of the Symphysis Pubis

If you are currently experiencing any of the following conditions, consult your health care practitioner before continuing massage

☐ Bladder Infection ☐ History of Miscarriage ☐ Phlebitis or Blood Clot ☐ Hypertension ☐ Gestational Diabetes

If you are currently experiencing any of the following conditions, massage therapy is NOT advised without express consent from your prenatal health care practitioner.

☐ Problems with Placenta ☐ Pre-eclampsia/Eclampsia ☐ Visual Disturbances ☐ Bleeding ☐ Abdominal Cramping

Other Conditions/Concerns

Signature:____

Date of intial intake: ________________________________

Update 1:________________ Update 2:________________

Update 3: Update 4: