Health History Form

Mary Houle, RMT

It is important that your massage therapist obtains an accurate health history to ensure that it is safe for you to receive massage therapy. All information is confidential except as required by law or unless consent is given for information to be released. Also, if there are any changes in the future to your health history form please let your therapist know.

Name:_____ Gender:_____
Address:_____ Date of Birth:_____
_____ Emergency contact and #: _____
Phone number:_____ Doctor's Name:_____
Who referred you:_____ Doctor's Address:_____
Occupation:_____
Primary complaint:_____
Present involvement in other Health Care Modalities:_____
General Health Status:_____
History of Massage Therapy: YES NO _____
Email (for use of self-care information, apt information/reminders/receipts):
_____

Please indicate any conditions that you have experienced in the past or are presently experiencing:

Respiratory
- ☒ Chronic cough
- ☒ Shortness of breath
- ☒ Bronchitis
- ☒ Asthma
- ☒ Emphysema
- Syndrome.
- ☒ Allergies/Sinusitis
- ☒ Frequent Colds
- ☒ Recurrent Lung Infection

Other:_____

Cardiovascular
- ☒ High blood pressure
- ☒ Low blood pressure
- ☒ Chronic congestive
- ☒ Heart failure
- ☒ Heart attack
- ☒ Phlebitis
- ☒ Pacemaker
- ☒ Stroke/CVA

Other:_____

Nervous System
- ☒ Spinal Cord Injury
- ☒ Numbness/Tingling
- ☒ Sensory Change/Loss
- ☒ Sciatica
- ☒ Thoracic Outlet
- ☒ Seizures/Epilepsy
- ☒ Multiple Sclerosis
- ☒ Cerebral Palsy

Other:_____

Discomfort
- ☒ Neck
- ☒ Shoulder
- ☒ Arm
- ☒ Wrist/Hand
- ☒ Upper Back
- ☒ Mid Back
- ☒ Lower Back
- ☒ Hip
- ☒ Leg
- ☒ Knee
- ☒ Ankle/Foot

Head/Neck
- ☒ Whiplash
- ☒ Headache
- ☒ Migraine
- ☒ Concussion
- ☒ Ringing in the ears
- ☒ Hearing Loss
- ☒ Vision Problems
- ☒ Brain Injury
- ☒ TMJ

Other:_____

Bone/Joint
- ☒ Pain
- ☒ Sprain
- ☒ Swelling
- ☒ Limited Movement
- ☒ Dislocation_____
- ☒ Fracture_____
- ☒ Arthritis (RA / OA)
- ☒ Degenerative Disc Disease
- ☒ Prolapsed Herniated Disc
- ☒ Family History of Arthritis

Other:_____

Other:_____

OVER→

Infections
☒ Hepatitis
☒ Skin conditions
☒ TB
☒ HIV
Syndrome
☒ AIDS
Other:_____
Diabetes:_____

Digestive
☒ Constipation
☒ Diarrhea
☒ Crohn's
☒ Irritable Bowel Syndrome.
☒ Ulcers
☒ Diverticulitis
☒ Nausea

Disease/ Condition
☒ Cancer: benign/malignant
treatment_____
☒ Fibromyalgia
☒ Chronic Fatigue
☒ Allergies:_____
☒
Other:_____

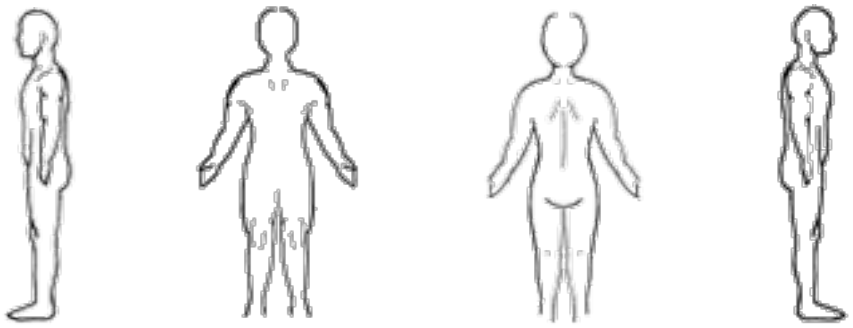
Muscle/ Soft Tissue
☒ Pain
☒ Strain
☒ Stiffness
☒ Restricted Movement
☒ Tendonitis
☒ Hyperkyphosis
☒ Hyperlordosis
☒ Scoliosis
Other:_____

Skin
☒ Frostbite
☒ Sensitive Skin:
_____
☒ Cold Sores
☒ Contagious/Infectious Condition
☒ Rash/ Eruptions
☒ Warts
☒ Herpes
Other:_____

Women Only
☒ Pregnancy
due date:_____
complications:_____
_____
☒ Vaginal Birth
☒ Gynecological Conditions
_____
☒ Menstrual Problems
Other:_____

Please indicate your areas of pain or other symptoms on the diagrams below:

Left Front Back Right



Current Medications:_____
_____
Surgeries (Dates):_____
_____
Injuries/
Accidents(Dates):_____
_____
Other Medical conditions not listed above:_____
_____
Of special note (pins, wires, artificial joints, etc.):_____

Consent: I have provided accurate information to the best of my knowledge above. I understand that I have the right to ask questions about my treatment. I also have the right to ask the therapist to stop or change the treatment at any time. I consent to therapeutic massage treatment by Mary Houle RMT.

Date:_____ Updated(therapists use)

Client's Signature:_____
Therapist's Signature:_____