Health History Form

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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. You will be asked to provide written permission before information is released. Also, if there are any changes in the future to your health history form please let your therapist know.

Name:_____ Doctor's name:_____
Address:_____ Doctor's address:_____
_____ Date of birth:_____
Phone number:_____ Emergency contact and #:_____
Who referred you:_____ Gender:_____
Occupation:_____
Primary complaint:_____
Present involvement in other Health Care Modalities:_____
General Health Status:_____
History of Massage Therapy: YES ☐ NO ☐_____

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

Respiratory
- ☐ Chronic cough
- ☐ Shortness of breath
- ☐ Bronchitis
- ☐ Asthma
- ☐ Emphysema
- ☐ 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 Syndrome.
- ☐ Seizures/Epilepsy
- ☐ Multiple Sclerosis
- ☐ Cerebral Palsy

Other:_____

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

Other:_____

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:_____

OVER→

Infections
- [ ] Hepatitis
- [ ] Skin conditions
- [ ] TB
- [ ] HIV
- [ ] AIDS

Other:_____

Digestive
- [ ] Constipation
- [ ] Diarrhea
- [ ] Crohn's
- [ ] Irritable Bowel Syndrome.
- [ ] Ulcers
- [ ] Diverticulitis
- [ ] Nausea

Disease/ Condition
- [ ] Cancer: benign/malignant
  treatment_____
- [ ] Fibromyalgia
- [ ] Chronic Fatigue Syndrome
- [ ] Allergies:_____
- [ ] Diabetes: _____

Other:_____

Muscle/ Soft Tissue
- [ ] Pain
- [ ] Strain
- [ ] Stiffness
- [ ] Restricted Movement
- [ ] Tendonitis
- [ ] Hyperkyphosis
- [ ] Hyperlordosis
- [ ] Scoliosis

Other:_____

Skin
- [ ] Frostbite
- [ ] Sensitive Skin
- [ ] Herpes
- [ ] Cold Sores
- [ ] Contagious condition
- [ ] Rash/ Eruptions
- [ ] Infectious Conditions

Other:_____

Women Only
- [ ] Pregnancy

due date:_____

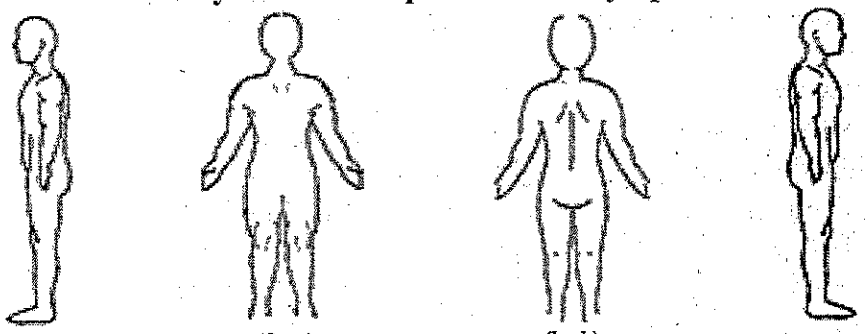
complications:_____

_____
- [ ] Vaginal Birth
- [ ] Gynecological Conditions

_____
- [ ] Menstrual Problems

Other:_____

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



(front) (back)

Current Medications:_____

Surgeries:_____

Injuries/Accidents:_____

_____

Other Medical conditions not listed above:_____

_____

Of special note (pins, wires, artificial joints, etc.):_____

_____

Consent: 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 have also provided accurate information to the best of my knowledge above. I consent to therapeutic massage treatment by the above named massage therapist. I consent to the sharing of my health history and treatment information in the context of this clinic with other health care providers for the best interest of my health and treatment planning. I also understand that 24 hours notice is required to reschedule all future appointments, or full charges will apply.

Date:_____

Client's Signature:_____

Therapist's Signature:_____

Updated(therapists use)
