Massage Therapy Health History

Name: ______________________________ Phone: (h)______________ (w)________________
Address: ____ Postal Code: ________________
Email Address: ____
Birthdate: ____/_____/_______ Occupation: ____
day month year
Signature: ______________________________________ Date: __________________________

Please check the conditions that you are currently experiencing or have experienced often in the past year. Accurate information is necessary so that your therapist is able to prepare a safe and effective treatment plan.

Head/Neck
- ☐ headaches
  type: ____________________
- ☐ migraine (with aura)
- ☐ vision problems
- ☐ contact lenses
- ☐ earaches

Respiratory
- ☐ chronic cough
- ☐ emphysema
- ☐ asthma
- ☐ bronchitis
- ☐ shortness of breath
- ☐ smoking
- ☐ breathing problems
  type: ____________________

Cardiovascular
- ☐ high blood pressure
- ☐ low blood pressure
- ☐ poor circulation
- ☐ heart disease
- ☐ pacemaker
- ☐ CCHF
- ☐ heart attack
  date: ____________________
- ☐ cerebral vascular accident
- ☐ phlebitis
- ☐ stroke
- ☐ varicose veins
  Dr. diagnosed? ____________

Skin
- ☐ skin condition
  type: ____________________
- ☐ bruise easily

Other Conditions
- ☐ difficult digestion
- ☐ constipation
- ☐ liver ____________________
- ☐ gall bladder ______________
- ☐ kidney ___________________
- ☐ bladder __________________
- ☐ diabetes, onset ____________
- ☐ seizures
- ☐ allergies __________________
- ☐ insomnia
- ☐ cancer ____________________
- ☐ sinus
- ☐ arthritis
  Dr. diagnosed? ____________
  affected areas _____________

Infections
- ☐ herpes
- ☐ hepatitis
- ☐ plantar warts
- ☐ tuberculosis
- ☐ HIV
- ☐ other ____________________

Medical Doctor
Name ______________________
Phone # ___________________
Last visit ___/____/_____
day month year

Women
- ☐ menstrual problems
- ☐ gynecological surgery

____
- ☐ pregnant, due__________
- ☐ menopausal problems

____
Number of pregnancies____

Surgery
Type: __________________
Date: __________________
Current Symptoms _______
____

Injuries/Accidents
Type: __________________
Date: __________________
Current Symptoms _______
____

Presence of :(& location)
- ☐ pins _________________
- ☐ wires ________________
- ☐ artificial joints __________
- ☐ special equipment ______

Other
____
____
____
____
____
____

Note: The information on this form is confidential and will be used for no other purpose than for this clinic. Only when legally bound will this information be shared. This form is to be updated annually. Any changes to your health should be mentioned to your therapist as soon as possible. If you have any questions relating to this form, please speak to your therapist.

Please list all current medications, including nutritional supplements/ vitamins, and the condition they are used for:

____ ____
____ ____
____ ____
____ ____
____ ____

Please note other health professionals that you working with and what they are treating (i.e. chiropractic, physiotherapy, naturopathic, reflexology, etc.)

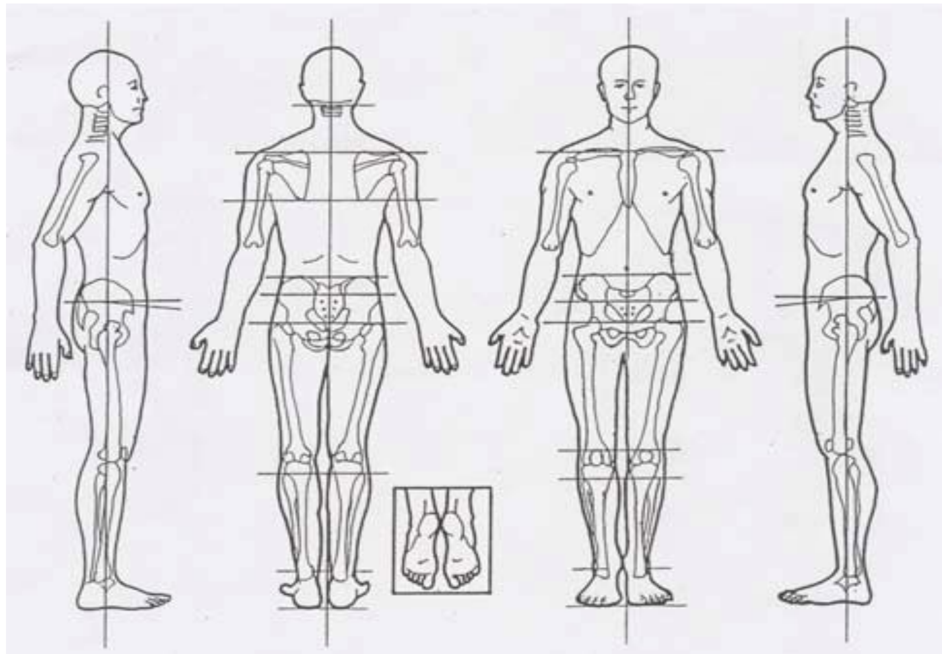
____ ____
____ ____
____ ____
____ ____
____ ____

What is the main reason for your visit today? ____
____

Is this a chronic condition, or a new concern? ____
If new, when did symptoms begin? ____

On the diagram below please indicate the areas of concern:

muscle tightness	mmm
tender areas	ttt
tingling sensation	sss
Other	ooo



Is there any other information that you feel is necessary for your therapist to know?

____
____
____