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 not 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:____
Occupation:____________________________ Date of Birth:____________
Email Address:____
Have you received massage therapy before? Yes No
If yes, please provide their name and address.________________________

Please indicate conditions you are experiencing or have experienced:

Cardiovascular	**Infections**	**Head/Neck**
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 the above? Yes No **Respiratory** Chronic cough Shortness of breath Bronchitis Asthma Emphysema Is there a family history of the above? Yes No	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 family history of arthritis? Yes No	History of headaches History of migraines Vision problems Vision loss Ear problems Hearing loss **Women:** Pregnant, due:____________ Gynaecological conditions, what?____________ Overall, how is your general health? ________________ Primary Care Physician: ________________ Address:____________ ________________

Current Medications: ________________ Condition it treats:____________ ________________ Are you currently receiving treatment from another health care professional? Yes No If Yes, for what? ____________ ________________ Surgery- date ____________ Nature: ____________ Injury- date____________ ________________	Do you have any other medical conditions? (e.g. digestive condition, haemophilia, osteoporosis, mental illness) Yes No 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. ________________ ________________ ________________

Date of Initial Health History:____________
Update 1:__________ Update 2__________ Update 3 __________ Update 4__________