HEALTH HISTORY FORM

Policy: An accurate health history is important to ensure that it is safe for you to receive a massage treatment. If your health status changes in the future, please let me know. All information gathered for this treatment is confidential except as required or allowed by law or except to facilitate diagnosis (assessment) or treatment. You will be asked to provide written authorization for release of any information.

Consent_____ 24hrs Screen_____ Day of Screen_____ Temp_____ Therapist:_____

Patient's Name: _____ Date: _____

Address: _____

Occupation: _____ Date of Birth: _____

Telephone: (Home) _____ (Cell) _____ Text: Y/N

Who referred you? _____ Email: _____

Doctor (name/address):_____

What brings you in for massage? _____

Involvement in Other Health Care: _____

Type of Pain: (please circle) Sharp, Dull, Tingling, Burning, Aching, Constant, Boring, Excruciating Typical
Intensity of this Discomfort (circle one): 0 1 2 3 4 5 6 7 8 9 10

Health History: Please indicate conditions you are experiencing, or have experienced.

RESPIRATORY ○ Chronic Cough ○ Shortness of Breath ○ Bronchitis ○ Asthma ○ Emphysema ○ Congestion ○ Smoking (Heavy/Light)	**CARDIOVASCULAR** ○ High Blood Pressure ○ Low Blood Pressure ○ Phlebitis ○ Stroke/CVA/Heart Attack/CCHF ○ Heart Attack ○ Pacemaker ○ Varicose Veins ○ Poor Circulation ○ Dizziness	**SKIN** ○ Bruise easily ○ Skin conditions ○ Skin allergies ○ Skin Infections ○ Rash/Cold Sores **Please Specify:** _____ _____
INFECTIONS ○ Hepatitis ○ TB ○ HIV ○ Kidney/Bladder ○ Other _____	**HEAD/NECK** ○ Vision Problems ○ Vision Loss ○ Ear Problems ○ Hearing Loss ○ Headaches Type: _____ ○ Frequent Colds ○ Sinus Infections	**DIGESTIVE** ○ Poor/Excessive Appetite ○ Constipation/Diarrhea ○ Nausea ○ Gas ○ Difficult Digestion ○ Pain ○ Liver/Gallbladder ○ Other

OTHER CONDITIONS

- Loss of sensation i.e hands, feet
- Diabetes
  Onset: _____
- Allergies
- Epilepsy
- Cancer
- Osteoarthritis/Rheumatoid Arthritis
  Date Diagnosed: _____
  Joints Affected:
  _____

Is there a family history of arthritis:

- Yes Type_____
- No

WOMEN

- Pregnant
  Due: _____
- Children
  #: _____
- Menopause
- PMS
- IUD
- Menstration
  (painful/heavy/scant)

Supplements: _____
_____

SOFT TISSUE/JOINT DISCOMFORT

- Neck_____
- Low Back_____
- Mid Back_____
- Upper Back_____
- Shoulders_____
- Arms_____
- Legs_____
- Knees_____
- Other_____
- Intensity of this Discomfort Today: 0 1 2 3 4 5 6 7 8 9 10
- Overall Health (check one): Poor_____ Moderate_____ Good_____ Excellent_____

Have you had Massage Therapy before? NO_____ YES_____ Date of last Massage_____

Surgeries/Injuries, Dates & Current Symptoms: _____

_____

_____

Other Medical Conditions (Nervousness/Depression/Hemophilia/etc.): _____

_____

Current Medications & Condition(s) Treated: _____

_____

Any Internal Pins, Wires, Artificial Joints or Special Equipment: Y/N _____

Emergency Contact Name_____ #_____

I have read, understood & agreed to all personal information , policies on this form, fee schedule and understand and agree to pay HALF the session fee for cancelling my appointment with less than 24 hours notice and paying the FULL session fee for missing my appointment with no notice. No Charge for appointments cancelled with 24 hours notice.

Client Signature: _____ **Date:** _____