

HEALTH HISTORY

An accurate health history is important to ensure that it is safe for you to receive 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/allowed by law, or except to facilitate diagnosis (assessment) or treatment. Note: You will be asked to provide written authorization for the release of any information.

I regret I must charge for appointments cancelled with less than 24 hours notice.

Initials

Date (mm/dd/yyyy)

Name: _____ Phone: Home: _____

Occupation: _____ Work: _____

Address: _____
Street City Postal Code

Date of Birth: _____ Height: _____ Weight: _____

Medical Doctor: _____ Date of last visit: _____

Address: _____ Phone: _____

Where did you hear about the clinic? _____
(Please be specific e.g. name of doctor, name of friend, yellow pages, etc.)

What brings you in for a massage? _____

When did it start? _____

In regards to pain: Intensity: 0 1 2 3 4 5 6 7 8 9 10
Mild Moderate Severe

Frequency: constant _____? comes and goes _____?

Has there been a medical diagnosis? Yes: ___ what was the diagnosis? _____

No: _____

Were x-rays taken? _____ Date: _____

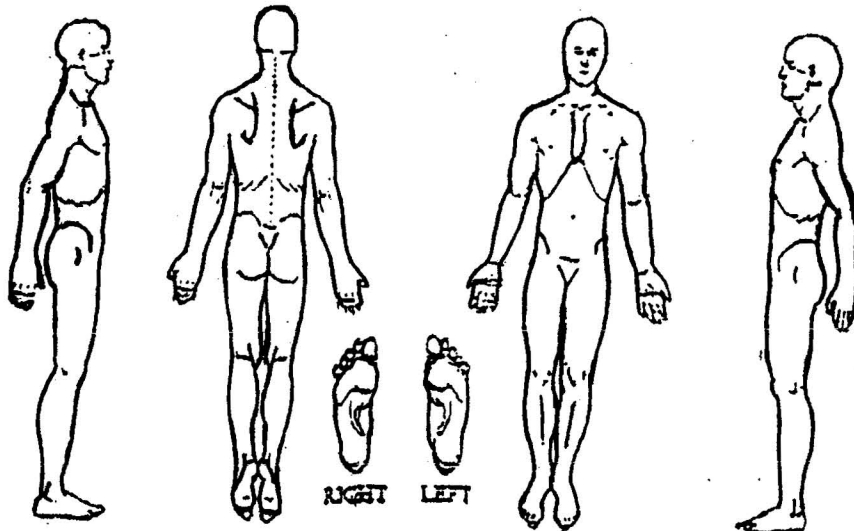
List other areas of minor complaints or concerns: _____

Current Medications:

Name

For What Condition?

Please indicate your symptoms on diagrams:
 X - pain/stiffness
 N - numbness/tingling



Please fill out both sides →

(Health History continued)

Please check all that apply:

Head/Neck

- Headaches
type: _____
- Vision problems
- Contact lenses
- Earaches
- Hearing Loss
- TMJ dysfunction

Respiratory

- Chronic cough
- Shortness of breath
- Smoking
- Asthma
- Emphysema
- Other breathing problems
Type: _____

Cardiovascular

- High blood pressure
- Low blood pressure
- Poor circulation
- Heart disease
- Phlebitis
- Varicose veins
Dr. diagnosed? ___
- Stroke/TIA

Skin

- Bruise easily
- Skin conditions
type: _____
- Other: _____

Women

- Menstrual problems
 heavy painful scant
- Pregnant? Due: _____
- Menopause
- C - section/other gynecological surgery? _____

Men

- Prostrate
- Testicular cancer

Digestive/Urinary

- Difficult digestion
- Constipation
- Liver
- Gallbladder
- Kidney
- Bladder
- Diabetes onset: _____
Type I ___ Type II ___

Other Conditions

- Sinus
- Allergies
- Insomnia
- Cancer _____
- Arthritis
Dr. diagnosed? _____
Affected area(s) _____

Surgery

- Type: _____
- Date: _____
- Current Symptoms: _____
- Type: _____
- Date: _____
- Current Symptoms: _____

Of special note: (pins, plates, wires, artificial joints, pacemaker) _____

Disclaimer

I hereby certify that I have read and understand all the questions relative to my health and medical history. I have completed all the information accurately and I am aware of no other health conditions not specifically mentioned on the above questionnaire.

I hereby absolve the attending Registered Massage Therapist of all claims and responsibility for detrimental effects to my health as a result of my massage therapy treatment.

I hereby certify that I have properly informed the attending Registered Massage Therapist of any known infectious disease, high blood pressure, pregnancy and/or surgical implants such as, pins, rods, artificial joints or pacemakers.

Patient Signature: _____

Date: _____

Witness Signature: _____