

Registered Massage Therapy – Health History Form

The information requested below will assist us in treating you safely. Feel free to ask any questions about this information. Please note that all information provided below will be **kept in confidence** unless allowed or required by law. Your written permission will be required to release any information.

Patient Name: _____ Phone# _____
 Address: _____
 Occupation: _____ Date of Birth: _____
 E-mail Address: _____

Have you received massage therapy before? ___ Yes ___ No
 Did a health care practitioner refer you for Registered Massage Therapy? ___ Yes ___ No
 If yes, please provide their name: _____

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

<u>Cardiovascular</u>	<u>Infections</u>	<u>Head/Neck</u>
<input type="checkbox"/> high blood pressure	<input type="checkbox"/> hepatitis	<input type="checkbox"/> history of headaches
<input type="checkbox"/> low blood pressure	<input type="checkbox"/> skin conditions	<input type="checkbox"/> history of migraines
<input type="checkbox"/> chronic congestive heart failure	<input type="checkbox"/> TB	<input type="checkbox"/> vision conditions
<input type="checkbox"/> heart attack	<input type="checkbox"/> HIV	<input type="checkbox"/> vision loss
<input type="checkbox"/> phlebitis/varicose veins	<input type="checkbox"/> Herpes	<input type="checkbox"/> ear conditions
<input type="checkbox"/> stroke/CVA		<input type="checkbox"/> hearing loss
<input type="checkbox"/> pacemaker or similar device	<u>Women</u>	
<input type="checkbox"/> heart disease	<input type="checkbox"/> pregnant, due:	
	<input type="checkbox"/> gynecological condition	
Is there a family history of any of the above? <input type="checkbox"/> Yes <input type="checkbox"/> No		
<u>Respiratory</u>	<u>Other Conditions</u>	<u>General</u>
<input type="checkbox"/> chronic cough	<input type="checkbox"/> loss of sensation	<u>Primary Care Physician</u>
<input type="checkbox"/> shortness of breath	<input type="checkbox"/> diabetes, onset: _____	Name: _____
<input type="checkbox"/> bronchitis	<input type="checkbox"/> arthritis	Address: _____
<input type="checkbox"/> asthma	<input type="checkbox"/> skin conditions	
<input type="checkbox"/> emphysema		
Is there a family history of any of the above? <input type="checkbox"/> Yes <input type="checkbox"/> No	Are you allergic to anything? What? _____	

Do you have any other medical conditions (ex. Digestion conditions, hemophilia, osteoporosis, mental illness)?
 Yes No _____

Please list your current medications and the condition it treats: _____

Are you currently receiving treatment from another health care professional? _____

Registered Massage Therapy – Health History Form (Pg. 2)

Do you have any internal pins, wires, artificial joints or special equipment? Yes No

Surgery? - date: _____ nature: _____

Injury? - date: _____ nature: _____

What is your reason you are seeking massage therapy? Please include the location of any tissue or joint discomfort:

I declare that the information provided above is accurate and filled out to the best of my ability.

Signature

Date