Client Health History

An accurate health history Is important to ensure that it is safe for you to receive a massage treatment. 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, Feel free to ask any questions about the information requested.

Date of initial health history:

Update _____
2_____
3 _____
4 _____

Name: _____ Date: _____
Address: _____Email: _____
Telephone: (Home)_____(Work) _____ (Cell) _____
Date of Birth: _____
Who referred you? _____ Occupation: _____

Please indicate conditions you are experiencing, or have experienced before:

Cardiovascular
_ high blood pressure
_ low blood pressure
_ CCHF
_ heart attack
_ heart disease
_ phlebitis
_ stroke
_ varicose veins
_pacemaker or similar device

Is there a family history of any of the above? Y N

Respiratory
_ chronic cough
_ shortness of breath
_ bronchitis
_ asthma
_ emphysema

Is there a family history of any of the above? Y N

Infections
_ Hepatitis
_ Skin conditions
_ TB
_ HIV
_ Herpes

Head/Neck
_ headaches/migraine
_ vision loss
_ vision problems
_ earache
_ hearing loss
_ sinus problems
_ allergies
_ frequent colds

Other
_ Cancer
_ Diabetes
_ Epilepsy
_ Arthritis
Where?_____
_ Fibromyalgia
_ Loss of sensation
Where?_____
_ Skin conditions
What? _____
_ Allergies/hypersensitivity
To what?_____
What type of reaction?
_____

Women
Pregnant Y N due: ____
Gynecological conditions
Y N What? _____

Muscles and joints
_ neck L/R
_ shoulders L/R
_ upper back
_ mid back
_ low back
_ arms L/R
_ wrists L/R
_ legs L/R
_ ankles L/R
_ TMJ
_ swelling

Current overall health

_____

Other medical conditions

_____
_____
_____

Presence of internal pins, wires, artificial joints, special equipment, etc:
_____

Current medications: _____ Physician: _____
For _____ Address: _____
Supplements: _____ Phone: _____
Surgeries- Date;_____ _____Nature:_____
Injuries- Date:_____Nature: _____
Present involvement in other health care Y N What?_____
What is the reason you are seeking massage therapy?_____

It is our office policy to charge a fee for any missed appointments and for cancellations within **Six hours of your scheduled appointment time**.

Client Signature _____ Date _____