Confidential Health History Form

The information provided below will assist our therapists in providing you with the best care possible. The information is confidential, and will not be shared unless requested, or required by law. Your written permission will be required prior to release of any information.

Name: ____ Birthdate: ______________________________________
Address:______________________________________ Emergency contact (name/phone):_________________________
City:__________________ Postal Code:______________ Family Physician (name/phone):____________________________
Phone: (home)___________________________________ Referred by:____________________________________
(work)___________________________________ Occupation:_____________________________________
(cell)____________________________________ email:____

Reason for coming:____
Have you received massage therapy before? Yes No

Please indicate all symptoms/conditions that you are experiencing (check or circle)

Cardiovascular
- High blood pressure
- Low blood pressure
- Chronic congestive heart failure
- Heart attack –date: _______________
- Stroke – date: ___________________
- Varicose veins
- Heart disease
- Pacemaker or similar device
- Circulatory disorder
- Bleeding disorder
- Other: ___________________________

Gastrointestinal
- Poor or excessive appetite
- Indigestion
- Nausea or vomiting
- Constipation or diarrhea
- Diabetes (type I or type II)

Women
- Pregnant, due: ___________________
- # of pregnancies: _________________
- Hot flashes
- Cramps or backache

Muscle and Joints
- Arthritis – where: _________________
- Swollen joints: ___________________
- Artificial joints, internal pins
- Neck pain/stiffness
- Back pain/stiffness
- Shoulder / elbow / arm
- Wrist / hand
- Hip / knee / leg
- Ankle / foot
- TMJ/jaw pain

Numbness, pain, tingling – where:
____
Weakness or loss of strength:
____

Head and Neck
- Headaches
- Migraines
- Vision problems (blurred, failing vision, double vision, eye pain): _____________________________
- Hearing loss
- Ringing or noise in ears
- Frequent colds
- Sinus infection

Respiratory
- Chronic cough
- Difficulty breathing
- Asthma
- Chest pain

General Symptoms and Conditions
- Dizziness or fainting
- Loss of sleep
- Nervousness / anxiety / depression
- Personality disorder
- Allergies: _______________________
- Cancer: _________________________
- Skin conditions: (rashes, dry skin, bruising) ______________________
- Infectious conditions: (HIV, hepatitis, etc) __________________________

Overall, how is your general health?
____

Are you on any medications?
____
____
____

Previous surgeries?
____
____
____

Previous injuries? (car accidents, hospitalization, fractures)
____
____
____

Do you smoke? Yes No

Do you exercise? Yes No Occasionally

Do you have any other medical conditions?
____
____
____

Today's date: ____________________
Update 1: ____________________
Update 2: ____________________
Update 3: ____________________
Update 4: ____________________