Initial Intake: ________
Update 1: ________
Update 2: ________
Update 3: ________

HEALTH HISTORY FORM – MASSAGE

Last Name:	First Name:	Date Of Birth (DDMMYYYY):	Gender o Male o Female
Address:		City:	Prov.:
Postal Code:	Email Address:		
Telephone Home:	Work:	Ext:	Cell:
Occupation:	Physician Name and Address:		Physician contact number:
Did a health care practitioner refer you for massage therapy? ___YES ___ NO If yes please provide their name ______________________ Other: ______________			Have you received massage therapy before? ___YES ___ NO
Please take a moment to tell us how you heard about us (Google, Yellow pages online, magazine, referral)			

GENERAL HEALTH INFO: Please indicate conditions you are experiencing or have experienced

Cardiovascular

__ High blood pressure
__ Low blood pressure
__ Chronic congestive heart failure
__ Heart attack
__ Phlebitis/varicose veins
__ Stroke
__ Pacemaker or similar device
__ Heart disease

Is there a family history of any of the above? __ Yes __ No

Respiratory

__ Chronic cough
__ Shortness of breath
__ Bronchitis
__ Asthma
__ Emphysema

Is there a family history of any of the above? __ Yes __ No

Are you currently receiving treatment from another health care professional?
___YES ___ NO. If yes for what?__________________

Infections

__ Hepatitis
__ Skin conditions
__ TB
__ HIV
__ Herpes

Other Conditions

Loss of sensation, where?
____
Diabetes, onset: ____________
Allergies/hypersensitivity:
____
type of reaction: ___________
Skin conditions: ______________
____
Cancer, where?
____
__ Arthritis
Is there a family history of any of the above? __ Yes __ No

Other medical concerns: ______
____

Head/Neck

__ History of headaches
__ History of migraines
__ Vision problems
__ Vision loss
__ Hearing loss
__ Ear problems

Women

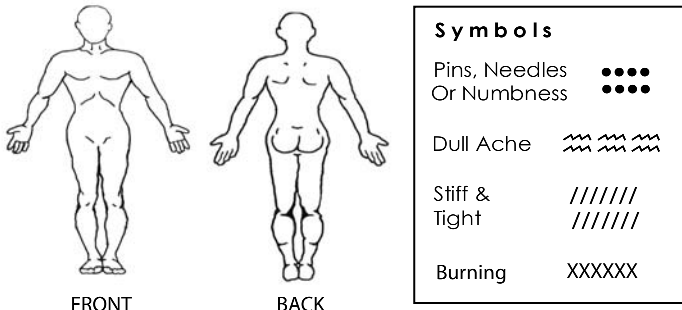
__ Gynaecological conditions
____
__ Pregnant
How many months: _________

Past surgeries: __________________
____

Current Medications: __________
____
Condition it treats: _____________
____

Do you have any internal pins, wires, artificial joints, or special equipment? ___YES ___NO
What? __________________________
Where? _________________________

AREAS OF CONCERN:
Primary complaint: ______________________________
Secondary complaint: ______________________________
Please indicate location of any muscular, joint or tissue discomfort on the diagram. Use the symbols to determine the type of discomfort or pain you are feeling.



Symbols

Symbol type	Symbol
Pins, Needles Or Numbness	●●●● ●●●●
Dull Ache	≈≈ ≈≈ ≈≈
Stiff & Tight	/////// ///////
Burning	XXXXXX

ALL CLIENT INFORMATION IS COMPLETELY CONFIDENTIAL AND WILL BE SAFEGUARDED BY THE THERAPIST

To Be Signed By the Client

I acknowledge that the above information is accurate and complete at this time. I understand that written and verbal consent will be ongoing. I also understand that I can alter or rescind my consent at any time during this and any treatment. I understand that during a massage if necessary the areas that might need to be worked on include: chest wall muscles, inner thigh muscles, and gluteal (buttocks) muscles.

At this time I am voluntarily giving my consent for treatment.

Date: ___________________ Name:________________________________
Signature:______________________________
Parent/Guardian signature (if under 16 years old): ______________________________