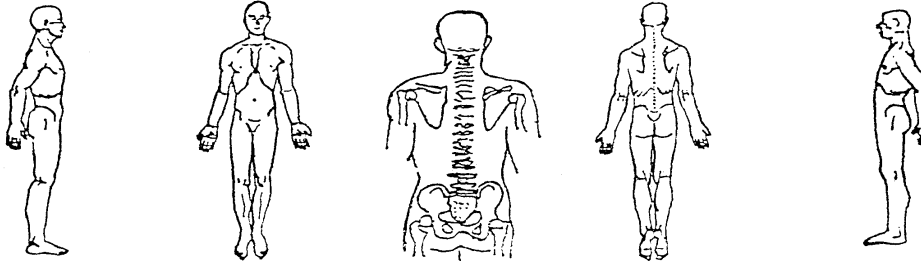


Confidential Health History Form

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. Written authorization will be required for release of any information.
24 hour cancellation notice is required or a missed appointment fee will be charged.

Name: _____
Home:(_____) _____ Work:(_____) _____ Cell:(_____) _____
Address: _____ City: _____ Postal Code: _____
Date of birth: ____/____/____ Occupation: _____ First time for Massage Therapy: YES / NO
Family Physician: _____ Address: _____
Who can we thank for referring you here? _____ If Doctor – Address: _____
Reason for Massage Therapy Treatment: _____

Indicate pain and/or stiffness by shading in the area – Indicate numbness and/or tingling with an ‘N’ or ‘T’



Health History: Please check spaces below for any conditions that you are experiencing or have experienced

Soft Tissue/Joints

- tendonitis / bursitis
- weakness _____
- sprains / strains
- arthritis – OA / RA / other
- location: _____
- herniated discs

Headaches

- tension headaches
- migraines
- tooth / jaw/ ear pain (circle)
- head trauma – date: _____

Accident / Injury

- car accident
- whiplash
- date: _____
- symptoms: _____
- physical limitations: _____
- fractures

Women

- pregnant – due date: _____
- gynaecological conditions

Surgery

Type: _____
Date: _____
Current symptoms: _____

Respiratory

- chronic cough
- shortness of breath
- bronchitis
- asthma
- emphysema
- pneumonia
- sinus problems

Cardiovascular

- high blood pressure
- low blood pressure
- heart attack
- phlebitis
- stroke / CVA
- pacemaker
- heart disease
- angina
- chronic congestive heart failure

Infectious Disease

- hepatitis
- tuberculosis
- HIV/AIDS
- other: _____

Current Medications & Conditions

Skin

- skin condition:
- bruise easily
- herpes
- varicose veins
- athlete's foot
- warts / plantar warts
- loss of sensation

Other Conditions

- neurological conditions
- epilepsy
- diabetes-onset: _____
- allergies - **anaphylaxis Y / N**
- cancer _____
- vision problems
- hearing loss or tinitis
- constipation
- other digestive conditions: _____
- insomnia / poor sleeping patterns
- kidney / bladder problems
- haemophilia
- fibromyalgia
- osteoporosis
- surgical implants (pins, plates, etc)

Present Involvement in Other Healthcare: YES / NO

If Yes Specify: _____

General Health Status: excellent / good / fair / poor

Family History of Arthritis? Yes / No

I have read the above information and have stated all my previous medical conditions. I take it upon myself to update the massage therapist regarding any changes in my condition. I understand that all massage treatments will be discussed and planned with the massage therapist, and will require my informed consent.

Signature: _____ **Date:** _____