Massage Confidential Health History Form

An accurate health history is important to ensure that it is safe for you to receive massage treatment. If your health status changes in the future, please let the therapist know. All information gathered is confidential at all times except as law requires. Please fill this form full and accurately to help create a safe and effective treatment.

Name: _____ Date: _____

Address: _____ Phone Number: _____

_____ Cell Number: _____

Date of Birth: _____ Occupation: _____

Physician Name: _____ Physician Number: _____

How did you hear of me: _____ Have you had a massage before: _____

Primary Complaint: _____

Type of pain (Achy, Shooting, Dull, etc): _____

Does it travel/radiate: ☐ Yes ☐ No If so, where to: _____

What tends to aggravate the pain: _____

What tends to relieve the pain: _____

Other complaints: _____

Your goals for treatments: _____

Please indicate any conditions you are experiencing or have experienced:

Musculoskeletal
- ☐ Bone/Joint Disease
- ☐ Tendinitis
- ☐ Bursitis
- ☐ Fractured Bones
- ☐ Carpel Tunnel
- ☐ Sprain/Strain
- ☐ Spasm/Cramp
- ☐ Dislocations
- ☐ Osteoarthritis
- ☐ Rheumatoid Arthritis
- ☐ Headaches
- ☐ Low Back Pain
- ☐ Leg/Ankle Pain
- ☐ Hip Pain
- ☐ Neck Pain
- ☐ Shoulder Pain
- ☐ Arm Pain
- ☐ Hand/Wrist Pain

Other: _____

Respiratory
- ☐ Chronic Cough
- ☐ Shortness of Breath
- ☐ Bronchitis
- ☐ Asthma
- ☐ Emphysema
- ☐ Sinus Problems

Other: _____

Cardiovascular
- ☐ High Blood Pressure
- ☐ CCHF
- ☐ Heart Attack
- ☐ Phlebitis
- ☐ Stroke/CVA
- ☐ Raynauds
- ☐ Varicose Veins
- ☐ Blood Clots

Other: _____

Digestive
- ☐ Constipation
- ☐ Gas
- ☐ Diverticulitis
- ☐ Chron's Disease
- ☐ Ulcerative Colitis
- ☐ Irritable Bowel Syndrome

Infections
- ☐ Hepatitis
- ☐ TB
- ☐ HIV

Other: _____

Reproductive
- ☐ Pregnant (due:_____)
- ☐ Menstrual Pain
- ☐ PMS

Other: _____

Other

Loss of Sensation
Where: _____
Diabetes
Allergies
Epilepsy
Cancer/Tumors
Hearing Problems
Vision Problems
Sleep Disorders
Addition

Skin

Rashes
Eczema
Psoriasis
Allergies
Warts
Burns
Other: _____

Are you currently seeing a medical practitioner (includes Chiro, Physio, etc.): _____

Current Medications: _____ What it treats: _____

Any previous injuries (car, sports, fall, etc.): _____

Any Surgeries (include description and approx. date): _____

Presence of: ☐ Internal Pins ☐ Wires ☐ Artificial Joints ☐ Special Equipment

Any other comments: _____

_____

Consent to Treatment

It is the therapists' only intention to provide the best treatment and care for your specific needs. However, as with all physical therapy, side effects and risks are to be associated with a massage treatment. The therapist should provide you with all the information necessary to make an informed decision about receiving your treatment. By signing this form you have acknowledged that you understand the proposed treatment and the intentions of the therapist, as well as giving your written consent for treatment to be administered.

Missed Appointment Fee

Please be advised that a **full charge** will be applied to any appointment that is missed. This is NOT covered by your extended health insurance benefits. Please respect the therapists' valued time, and should you need to cancel or reschedule an appointment, please call **24 hours** in advance. By signing below you agree to pay the missed appointment fee, should it need to be enforced.

_____

Print Name

_____ _____

Signature Date