PHYSIO HEALTH

MASSAGE HEALTH HISTORY FORM

The information requested below will assist us in treating you safely. Feel free to ask any questions. Please note that all the information provided below will be kept confidential unless allowed or required by law. Your written permission will be required to release any information.

Name:_____ **D.O.B.**_____(mm/dd/yy) **Age**:_____ ☐ **F** ☐ **M**

Have you received massage therapy before? ☐ Yes ☐ No

Did a healthcare practitioner refer you for massage therapy? ☐ Yes ☐ No

If yes, please provide their name & contact information: _____

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 / CVA
- ☐ Pacemaker or similar device
- ☐ Heart Disease
- ☐ Family History of any of the above

Head/Neck
- ☐ History of Headaches
- ☐ History of Migraines
- ☐ Vision Problems
- ☐ Vision Loss
- ☐ Ear Problems
- ☐ Hearing Loss

Respiratory
- ☐ Chronic Cough
- ☐ Shortness of Breath
- ☐ Bronchitis
- ☐ Asthma
- ☐ Emphysema
- ☐ Family History of any of the above

Other Conditions:
- ☐ Loss of sensation: _____
- ☐ Diabetes, onset: _____
- ☐ Allergies/hypersensitivities to: _____ Type of reaction: _____
- ☐ Epilepsy
- ☐ Cancer: _____
- ☐ Arthritis
  - ☐ Family history of arthritis

Infections
- ☐ Hepatitis
- ☐ Skin Conditions
- ☐ TB
- ☐ HIV
- ☐ Herpes

Women
- ☐ Pregnant, due: ____
- ☐ Gynaecological conditions: _____ _____

Other Medical Conditions:

_____
_____
_____
_____
_____

Current Medications & Conditions being Treated:

_____

Currently receiving treatment from another Health Care Provider? ☐ Yes ☐ No
If yes, specify: _____

Do you have any internal pins, wires, artificial joints or special equipment? ☐ Yes ☐ No
If yes, specify: _____

Surgeries
Date: _____ Type: _____
Date: _____ Type: _____
Date: _____ Type: _____

Injuries
Date: _____ Type: _____
Date: _____ Type: _____
Date: _____ Type: _____

Why are you seeking massage therapy? Please include the location of any tissue or joint discomfort.

_____

I certify that the information provided is true and accurate:

_____ _____
Date **Signature**

Date of Initial Health History: _____
Update 1 _____
Update 2 _____
Update 3 _____
Update 4 _____