



A Total Approach to Health and Wellness



THERAPEUTIC MASSAGE HEALTH HISTORY

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

Name: _____
Address: _____
City: _____ Prov: _____
Postal Code: _____
Phone (H): _____ (W): _____
(C): _____
EMAIL: _____

Date: _____
Referred By: _____
Family Physician: _____
Address: _____
Phone: _____
Emergency Contact: _____
Phone: _____

Female Male Birth date: _____
Occupation: _____
Do you smoke? No Yes
If yes, how much per day: _____

Are you, or are you possibly pregnant?
 No Yes
Expected due date: _____
Do you exercise regularly? No Yes
Frequency: _____x/week
Do you have any internal pins, wires, artificial joints or other special equipment (such as a pacemaker or hearing aid)? No Yes
If yes, please explain: _____

Medication/Vitamins	Condition

When was your last massage? _____

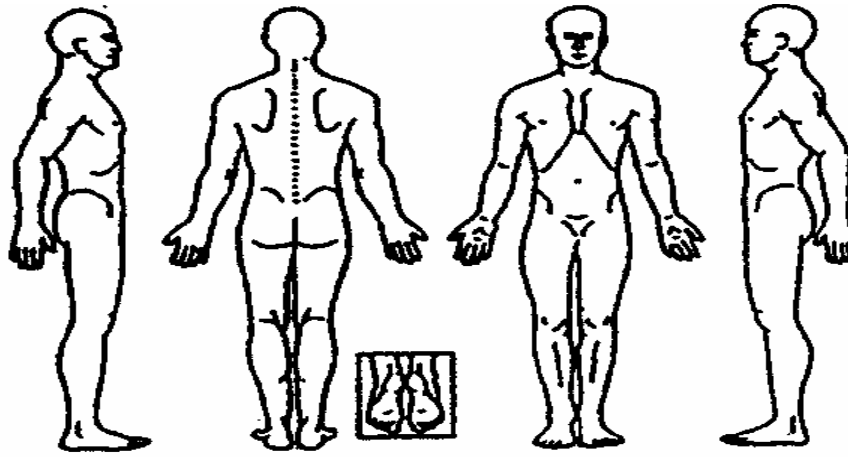
Have you ever been in a motor vehicle accident, sustained an athletic injury or other trauma?
 No Yes Please give a date and description of your injuries: _____

Have you ever been hospitalized? No Yes Have you ever had surgery? No Yes
Date and description: _____

What is the purpose of your visit? _____
What started this condition? _____
When did this condition begin? _____

Have you received treatment from other healthcare providers for this condition? No Yes
If yes, who are they and what type of healthcare provider are they:

PLEASE FILL OUT INFORMATION ON THE BACK



Please circle current symptomatic areas in your body on the diagrams above.

Have you been diagnosed with, or have you ever experienced any of the following?
 If **Yes**, please mark with a “**C**” for current issues and “**P**” for past on the line provided.

General

- Cancer/Tumors
- Diabetes
- Kidney problems
- Liver problems
- Drug/Alcohol addiction
- Infectious conditions (hepatitis, HIV, etc.)
- Eating disorder
- Recent abortion or vaginal birth
- Loss of vision/ hearing
- Headaches/ Migraines
- Numbness or tingling

- Deep vein thrombosis
- Chronic cough
- Bronchitis
- Asthma
- Emphysema
- Shortness of breath

- Jaw pain (TMJ)
- Whiplash
- Bursitis

Nervous system

- Epilepsy
- Multiple sclerosis
- Cerebral palsy
- Parkinson’s
- Nerve lesion
- Sciatica
- Carpal tunnel syndrome

Skin

- Sensitivities to oils, lotions, detergents
- Other allergies or hypersensitivities
- Irritated skin conditions
- Contagious conditions ie. Warts/ rashes.
- Frostbite
- Lack of sensation
- Inflammation

Circulatory/Respiratory

- Chronic congestive heart failure
- Heart disease
- Other heart condition
- High blood pressure
- Low blood pressure
- Varicose veins

Musculoskeletal

- Scoliosis
- Bone or joint disease
- Arthritis
- Joint instability
- Tendonitis
- Fractured bones

For Women Only

- Pregnancy
- P.M.S.
- Menstrual Cramps

Have you ever suffered from a:

Heart Attack? No Yes Date: _____ Stroke? No Yes Date: _____

Please list any other condition not listed & provide details as necessary