

# Health History Form

FYI: an accurate health history ensures that it is safe for you to receive a massage treatment, and helps the therapist determine a proper treatment plan. When your health status changes in the future, please let us know. All information gathered on this form is confidential. Your written authorization is legally required before any of this information can be released.

## Personal Information

Name: \_\_\_\_\_ Date: \_\_\_\_\_ Email: \_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_ Postal Code: \_\_\_\_\_

Home Phone: (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_ Work Phone: (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_ Cell Phone: (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_

Occupation: \_\_\_\_\_ Date of Birth: \_\_\_\_\_ Height: \_\_\_\_\_ Weight: \_\_\_\_\_

Reason for Massage: \_\_\_\_\_

On a scale of 1 to 10, where 1 is low and 10 is high, what is the usual intensity of your pain? \_\_\_\_\_

Have you had a massage before?  Yes  No  For relaxation or other reason? \_\_\_\_\_

Current Medications: \_\_\_\_\_

Previous Major Illnesses, Operations: \_\_\_\_\_

Accidents (please give dates): \_\_\_\_\_

Other Medical Conditions (e.g. hemophilia, diabetes): \_\_\_\_\_

Family History (major illnesses, operations): \_\_\_\_\_

Please indicate all conditions you have experienced. Mark C for current and P for past.

### Joint/Soft Tissue Discomfort:

- Arms
- Upper Back
- Mid Back
- Lower Back
- Degenerative Discs
- Feet
- Hands
- Hips
- Jaw
- Knees
- Legs
- Neck
- Osteo Arthritis
- Rheumatoid Arthritis
- Sciatica
- Shoulders
- Limitation of Movement

in which joints: \_\_\_\_\_  
Other: \_\_\_\_\_

### Skin:

- Rashes
- Itching
- Bruise Easily
- Dryness
- Boils
- Other: \_\_\_\_\_

### General Symptoms:

- Fainting
- Dizziness
- Loss of Sleep
- Fatigue
- Nervousness
- Sudden Weight Loss/Gain
- Numbness
- Tingling
- Paralysis
- Headaches (Tension)
- Migraines

### Cardiovascular:

- High Blood Pressure
- Low Blood Pressure
- Coronary Heart Disease
- Heart Attack
- Phlebitis
- Stroke / CVA
- Pacemaker
- Heart Murmur
- Palpitations
- Varicose Veins
- Swelling of the Ankles
- Poor Circulation

### Infectious:

- Hepatitis
- Tuberculosis
- Human Immunodeficiency Virus (HIV)
- Herpes
- Cold
- Flu
- Athlete's Foot
- Warts
- Other: \_\_\_\_\_

### Digestive:

- Poor Appetite
- Belching/Gas
- Constipation
- Diarrhea
- Nausea
- Ulcer
- Vomiting

### Eye, Ear, Nose, Throat:

- Allergies
- Frequent Colds
- Glasses or Contacts
- Hearing Aid
- Hearing Loss
- Sinus Infection
- Swollen Glands

(continued on next page)

Please indicate all conditions you have experienced. Mark C for current or P for past.

**Reproductive:**

- Pregnant
- due date: \_\_\_\_\_
- Painful Menstruation
- Heavy Flow
- Irregular Cycle
- Swollen Breasts
- Menopausal
- Pre-menopausal
- Post-menopausal
- Birth Control
- type: \_\_\_\_\_

**Respiratory:**

- Chronic Cough
- Bronchitis
- Asthma
- Hay Fever
- Difficulty Breathing
- Smoking
- Emphysema
- Pneumonia

**Lifestyle Questions**

Regular Eating Habits Yes No

Energy Level: High Average Low

Do you take vitamins? Yes No

Do you suffer from stress? Yes No

Type: \_\_\_\_\_

Cause: \_\_\_\_\_

Frequency: \_\_\_\_\_

Regular Exercise Yes No

Do you use a computer? Yes No

Type: \_\_\_\_\_

How many hours per day: \_\_\_\_\_

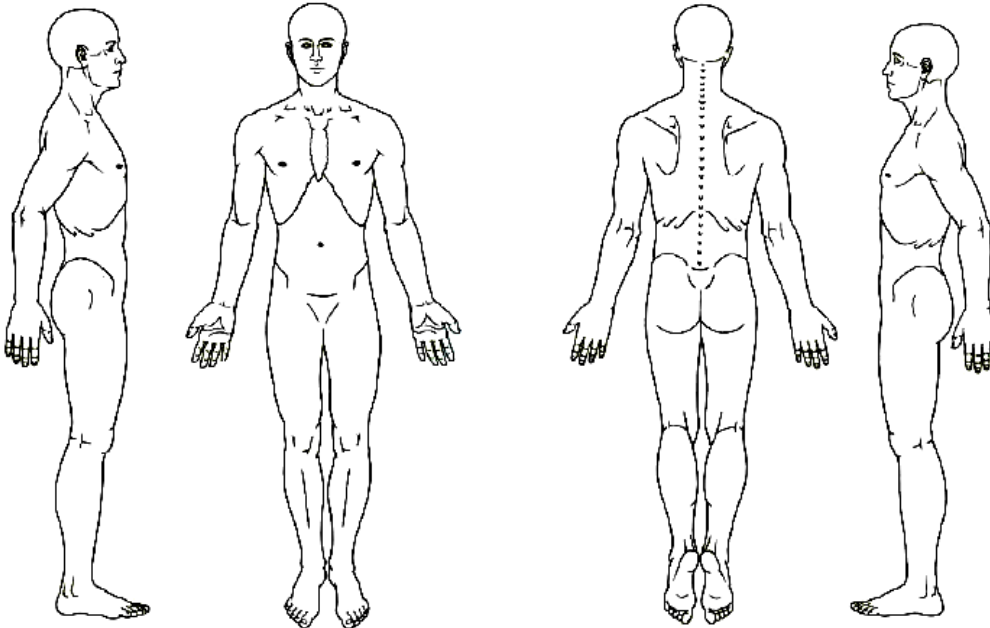
Frequency: \_\_\_\_\_

**Please read carefully, and sign.**

I attest that the information I have provided is true and complete to the best of my knowledge.  
I understand the information I have provided is confidential and will not be released without my written consent.  
I consent to therapeutic massage treatment.  
I also understand that I am responsible for any charges incurred in the course of my treatment.  
I understand that 24 hours notice is required to reschedule all future appointments, or full charges will apply.

\_\_\_\_\_  
signature

\_\_\_\_\_  
today's date



*This area to be filled out by the therapist.*

Treating Therapist: \_\_\_\_\_

Subjective Observations: \_\_\_\_\_

Objective Observations: \_\_\_\_\_

Analysis: \_\_\_\_\_

Plan: \_\_\_\_\_

