## 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:_____

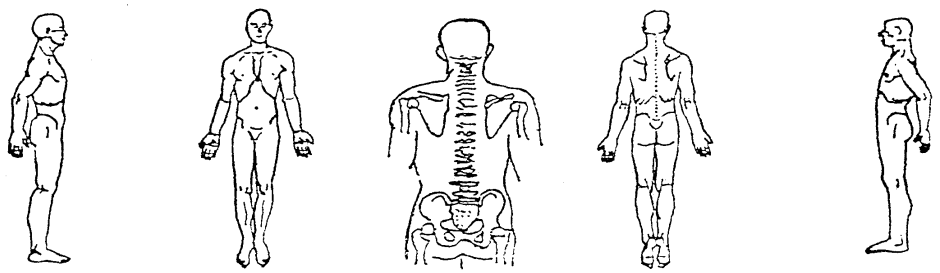
Date of birth:_____/_____/_____ Occupation:_____ First time for Massage Therapy: YES / NO
D M Y

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

**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: _____

**Skin**
- ❑ skin condition:
- ❑ bruise easily
- ❑ herpes
- ❑ varicose veins
- ❑ athletes 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)

**Surgery**
Type:_____
Date:_____
Current symptoms_____

**Current Medications & Conditions**
_____
_____
_____

**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 required my informed consent.

**Signature:** _____ **Date:** _____

Last Modified: May 25, 2007