This Health History Form, will assist me in providing you with a safe and an effective treatment. You must notify us of any changes in your health status. Please feel free to ask questions to better understand the health history questions being asked.

Please note that all information provided will be kept strictly confidential and will not be released to anyone without your prior written permission. ❑ Updated

Name: ______________________ D.O.B. (mm/dd/year): ______________________

Address: ______________________ City/Prov: ______________ Postal Code: __________

Tel #1: ______________ Tel #2: ______________ E-Mail: ______________________

Emergency Contact Name: ______________________ Tel: ______________

Occupation: ______________________ Family doctor: ______________________

Ever had massage before? Yes ❑ No ❑

Reason for Seeking Massage Today? (Specify when and how you were injured) ______________

Referred by? (Indicate name) ______________________

How would you characterize your general health? ______________________

Activities of Daily Living Disrupted by the presence of your condition ______________

Main Area(S) you wish me to focus on today (Specify) ______________________

Medications (Specify their names, and what they treat) ______________________

PLEASE MARK ANY OF THE CONDITIONS LISTED BELOW, THAT APPLY TO YOU:

RESPIRATORY SYSTEM CONDITIONS

Chronic Cough ❑ Emphysema ❑ Asthma ❑ Chronic Bronchitis ❑ Shortness of Breath ❑
Infectious Respiratory Conditions (sore/strep throat, etc) ❑

Do you smoke? Yes ❑ No ❑

Family history of Respiratory Conditions? (Specify) ______________________

Flip this page over to continue

CARDIOVASCULAR SYSTEM CONDITIONS

Heart Attack ❑ Stroke ❑ Pacemaker ❑ Aneurism ❑ Hi/Low BP ❑ Heart Disease ❑
Varicose Veins ❑ Atherosclerosis ❑ Bleed Disorder ❑ DVT (Clots) ❑ Heaviness in Limbs ❑

Family history of Cardiovascular Conditions? (Specify) ______________________________

DIGESTIVE SYSTEM CONDITIONS

Eating Disorders ❑ Abnormal Bowel Movements ❑ IBS ❑

Family history of Digestive Disorders? (List) ______________________________

INTEGUMENTARY SYSTEM CONDITIONS (SKIN)

Allergy to Heat ❑ Allergy to Cold ❑ Allergy to oils ❑ Eczema Psoriasis ❑ Acne ❑
Current Rashes/cuts/abrasions ❑ Current Open Sores/Wounds ❑ Cysts ❑
Swelling Anywhere ❑ Hives ❑

Any Other Allergies: (Specify) ______________________________

OSTEOLOGY SYSTEM CONDITIONS (BONES)

Osteoporosis ❑ Osteoarthritis ❑ Rheumatoid Arthritis ❑
Disc Disease Surgery (Pins – Screws – Plates – Wires)? ❑
Family history of bone disorders? (Specify) ______________________________

NERVOUS SYSTEM CONDITIONS

Seizures ❑ Epilepsy ❑ Hearing Impairment ❑ Sight Impairment ❑ Shakiness in Limbs ❑
Headaches (Specify) ❑ Sensory Impairment - Pins or Needles (Specify) ❑

Family history of neurological disorders? (specify) ______________________________

INFECTIOUS CONDITIONS

Hepatitis ❑ Herpes ❑ Warts ❑ Foot fungus ❑ Poison Ivy/Oak/Parsnip/Sumac ❑

STD/HPV/HIV (Specify) ______________________________

MISCELLANEOUS CONDITIONS

Pregnant ❑ Diabetes ❑ Hernia ❑ Cancer ❑ Haemophilia ❑ Mental Illness ❑

Is any of the above information you provided, recent? (Last 6 months) ____________________

I, the undersigned, acknowledge that the information I filled out on this Health History Form, is accurate, and complete.

______________________________ ______________________________

Signature Date

❑ Updated: ______________: ❑ Updated: ______________: ❑ Updated: ______________:

❑ Updated: ______________: ❑ Updated: ______________: ❑ Updated: ______________: