

# CONFIDENTIAL HEALTH HISTORY

## For your information:

An accurate health history is important to ensure that it is safe for you to receive a massage treatment. If your health status changes in the future, please let your therapist know. All information gathered for this treatment is confidential except to facilitate the assessment or treatment. You will be asked to provide written authorization for release of any information.

DATE: \_\_\_\_\_

NAME: \_\_\_\_\_ DATE OF BIRTH: \_\_\_\_\_

ADDRESS: \_\_\_\_\_ TEL: HOME: \_\_\_\_\_  
Postal Code: \_\_\_\_\_ BUS: \_\_\_\_\_  
CELL: \_\_\_\_\_

EMERGENCY CONTACT: \_\_\_\_\_ RELATIONSHIP: \_\_\_\_\_  
TEL: \_\_\_\_\_

WHAT IS YOUR PRIMARY COMPLAINT? \_\_\_\_\_  
\_\_\_\_\_

WHO REFERRED YOU? \_\_\_\_\_

**HEALTH HISTORY:** (Please indicate conditions you are experiencing currently as **C** and previous as **P**)

### Respiratory:

- Chronic cough
- Shortness of breath
- Bronchitis / asthma
- Sinus infections
- Chronic cough /  smoking
- Emphysema
- Other: \_\_\_\_\_

### Cardiovascular:

- Cold hands / feet
- High/ low blood pressure
- CCHF or heart attack
- Varicose veins or phlebitis
- Poor healing of wounds
- Stroke/ CVA
- Pacemaker or other device
- Swelling in hands/ feet

### Skin:

- Bruise easily
- Rash/ open sores/ warts
- Sensitivity / allergies
- Contagious skin disease

### Digestive:

- Constipation / diarrhea
- Nausea / vomiting
- Ulcers/ blood in stool
- Liver / kidney problems
- Quick weight gain/ loss
- Appetite changes
- Ulcerative colitis/crohn's/ IBS

### Other Conditions:

- Loss of sensation
- Diabetes (onset / type: \_\_\_\_\_)
- Hypoglycaemia
- Allergies
- Epilepsy
- Insomnia
- Depression / Anxiety
- Multiple Sclerosis
- Cancer (onset / type: \_\_\_\_\_)
- Other: \_\_\_\_\_

### Head and Neck

- Tension/ migraine headaches
- Tinnitus (ringing in ears)
- Tooth/ Jaw/ Ear pain
- Vision problems / loss
- Ear problems
- Hearing loss
- Dizziness/ lightheaded
- Other: \_\_\_\_\_

### Infections:

- Hepatitis
- Tuberculosis
- HIV
- Painful Urination
- Flank pain

### Women:

- Pregnant (due: \_\_\_\_\_)
- Painful menstruation
- Hysterectomy
- Birth control

### Soft tissue / Joint/ Nerve

- Fibromyalgia
- Arthritis \_\_ RA \_\_ OA \_\_ JRA
- Herniated disc(s) level \_\_\_\_\_
- Osteoporosis
- Fracture (where \_\_\_\_\_)
- Thoracic Outlet Syndrome
- Head trauma/ concussion
- Whiplash / car accident
- Neck pain/ stiffness / injury
- Shoulder pain/ stiffness /injury
- Arm pain/ weakness/ tingling
- Back pain/ stiffness / injury
- Leg pain / weakness/ injury
- Knee or foot pain/ injury
- Tendonitis/ tenosynovitis
- Bursitis or dislocations
- Sports / work related injury
- Repetitive strain injury
- Carpal tunnel syndrome

### Other Questions:

- I get a good night sleep
- I eat a well balanced diet
- I have low energy
- I feel good about life

### ADDITIONAL INFORMATION:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**Current medications:**

\_\_\_\_\_ condition it treats: \_\_\_\_\_  
\_\_\_\_\_ condition it treats: \_\_\_\_\_  
\_\_\_\_\_ condition it treats: \_\_\_\_\_  
\_\_\_\_\_ condition it treats: \_\_\_\_\_

**Family Physician:** \_\_\_\_\_

**Phone #:** \_\_\_\_\_

Present involvement in other Health Care: **Yes / No**  
**If yes, please specify:** \_\_\_\_\_

**Surgeries:**

\_\_\_\_\_ date: \_\_\_\_\_ details: \_\_\_\_\_  
\_\_\_\_\_ date: \_\_\_\_\_ details: \_\_\_\_\_

**Other medical conditions not mentioned (eg: digestive, hemophilia ; presence of any internal pins, wires, artificial joints):** \_\_\_\_\_

**What sports activities do you participate in on a regular or seasonal basis?**

I have read and completed this form and stated all medical conditions that apply to me to the best of my knowledge. I will notify the Massage Therapist of any changes in my health status to ensure my safety for receiving massage.

I understand that Massage Therapists do not diagnose illness, disease, or any physical/ mental disorder; nor do they prescribe medical treatment, pharmaceuticals, or perform chiropractic adjustments. I acknowledge that massage is not substitute for medical examination or diagnosis, and that it is recommended that I see a Medical Doctor for that service.

**I understand I must give 24 hours notice for cancellation of appointment and that I will be charged for the service fee if cancelled on that same day.**

**SIGNATURE:** \_\_\_\_\_ **DATE:** \_\_\_\_\_

<b>Please complete the diagram to show areas of pain, discomfort, injury or concern:</b>	
<b>O</b>	<b>Pain with a circle</b>
<b>^</b>	<b>Tender point</b>
<b>#</b>	<b>Previous fracture</b>
<b>α</b>	<b>Inflammation</b>
<b>~</b>	<b>Numbness/ tingling</b>
<b>≡</b>	<b>Tightness</b>
<b>≈</b>	<b>Spasm</b>

