HEALTH HISTORY

Name ______________________________ D.O.B. ______________________________
Full address ____
Home phone ________________________ Cell phone ___________________________
Email ____
Occupation ____
Have you received massage before? ___ Did a health care practitioner refer you for massage? ______ If yes, please provide their name ____________________________
How did you hear about us? ____
Primary Care Physician _______________ Address ____________________________
Current Medications ____
Condition it treats ____
Are you currently receiving treatment from another health care professional?
____
If yes, for what?
____
Surgery dates and their nature
____
Injury dates and their nature
____
____
____
Do you have any internal pins, wires, artificial joints or special equipment? If so, what and where? ____
What is the reason/intention you are seeking treatment? Please include the location of any tissue or joint discomfort. ____
____
____
Please check mark conditions you are experiencing or have experienced and mark a “F” beside the ailments if there is a family history of any of the above?:

high blood pressure　　low blood pressure　　chronic congestive heart failure

heart attack　　phlebitis/varicose veins　　stroke/CVA

pacemaker or similar device　　heart disease　　chronic cough

shortness of breath　　bronchitis　　asthma

emphysema　　hepatitis　　skin conditions ________

TB　　HIV　　herpes

loss of sensation, where? ____

diabetes, onset? ____

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allergies/hypersensitivity to what? _____________ type of reaction? ________________

epilepsy cancer, when and where? _____________________________________

skin conditions, what? ____

arthritis, where? ____

history of headaches history of migraines vision problems

vision loss ear problems hearing loss

pregnant, due? _______________ gynecological conditions, what? ______________

Overall, how is your general health? ____

____

Do you have any other medical conditions? (eg: hemophilia, osteoporosis, mental ill-ness, etc.) ____

____

Is there anything else I should know about before treating you? ____________________

____

NOTES FOR THERAPIST: ____

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