THE MASSAGE SHOPPE

BODY REPAIRS & MAINTENANCE

HEALTH HISTORY

* CONFIDENTIAL *

A complete health history form is essential to your massage therapist. This will ensure that it is safe for you to receive a massage therapy treatment. If your health status or personal information changes please let us know. All information gathered for this treatment is confidential, unless otherwise deemed by law, to facilitate a diagnosis or treatment plan. If this should occur then your (written) permission will be requested prior to release of any information.

Health history forms must be updated yearly.

Date: _____

Name: _____

Address:_____

Postal Code: _____ Date of Birth: _____

Occupation: _____

Home Phone: _____ Cell Phone: _____ Work Phone: _____

Email: _____

Extra Curricular Activities:

_____

What brings you in today?

_____

When did it start? _____ Have you seen a doctor for this? _____

What makes it better? _____ Worse? _____

When was your last massage therapy treatment? _____

How did you find us?

Road Signage: _____ Website: _____ Postcard: _____ Newspaper: _____ Social Media: _____
Sporting Event: _____ Community Event: _____ Walk-In: _____ Referral: _____
Other: _____

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Health History

Have you had or are you currently having any of the following conditions? (Please mark with a)

Does your family have a history of any of the following conditions? (Please mark with an X)

Respiratory
__ chronic cough
__ shortness of breath
__ bronchitis
__ asthma
__ emphysema
__ tuberculosis

Cardiovascular
__ high / low blood pressure
__ heart attack
__ phlebitis
__ stroke
__ pacemaker
__ heart disease
__ congestive heart failure
__ blood conditions
__ bruise easily

__ Pregnant? _____

Other Soft
__loss of sensation / numbness __neck
__ diabetes
__ allergies
__ epilepsy
__ cancer
__ osteoporosis
__ digestive conditions

Head / Neck
__ vision problems
__ ear / hearing problems
__ headaches
__ migraines
__ whiplash / conditions

Infections
__ hepatitis
__HIV
__ herpes
__ other _____

Tissue / Joint Problems
__ TMJ / jaw
__ low back
__ mid back
__ upper back
__ shoulders
__ arms / hands
__ hips
__ legs / knees / feet
__ arthritis
__pins / wires / artificial joints
__ other_____
_____

Skin Conditions
__ execema _____
__ psorasis _____
__ warts _____
__ melanoma _____
__ allergies _____

List current medications: _____
Herbal Supplements: _____
List all surgeries and dates: _____
Medical Doctor Name: _____ Phone #: _____
Address: _____ _____ Postal Code: _____
Are you currently seeing:
Chiropractor: _____ Physiotherapist: _____ Naturopath: _____ Pilates: _____ Acupuncturist: _____
Nutritionist: _____ Personal Trainer: _____ Yoga: _____