

# HEALTH HISTORY FORM

**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 me know. All information gathered for this treatment is confidential except as required or allowed by law or except to facilitate diagnosis (assessment) or treatment. You will be asked to provide written authorization for release of any information.

Name:	Date:
Home #:	Work #:
Address:	Fax/email:
Date of birth:	Occupation:
What is your primary complaint?	
Who referred you?	Their address?

**HEALTH HISTORY:** Please indicate conditions you are experiencing, or have experienced:

<b>Respiratory</b> <input type="checkbox"/> chronic cough <input type="checkbox"/> shortness of breath <input type="checkbox"/> bronchitis <input type="checkbox"/> asthma <input type="checkbox"/> emphysema	<b>Other Conditions</b> <input type="checkbox"/> loss of sensation <input type="checkbox"/> diabetes (onset: _____) <input type="checkbox"/> allergies (ie. anaphylaxis or skin irritation) <input type="checkbox"/> epilepsy <input type="checkbox"/> cancer <input type="checkbox"/> arthritis	<input type="checkbox"/> HIV <b>Women</b> <input type="checkbox"/> pregnant (due: _____)
<b>Cardiovascular</b> <input type="checkbox"/> high blood pressure <input type="checkbox"/> low blood pressure <input type="checkbox"/> CCHF <input type="checkbox"/> heart attack <input type="checkbox"/> phlebitis <input type="checkbox"/> stroke/CVA <input type="checkbox"/> pacemaker or similar device <input type="checkbox"/> heart disease	<b>Head/Neck</b> <input type="checkbox"/> vision problems <input type="checkbox"/> vision loss <input type="checkbox"/> ear problems <input type="checkbox"/> hearing loss	<b>Soft tissue/joint discomfort and its nature</b> <input type="checkbox"/> neck <input type="checkbox"/> low back <input type="checkbox"/> mid back <input type="checkbox"/> upper back <input type="checkbox"/> shoulders <input type="checkbox"/> arms <input type="checkbox"/> legs <input type="checkbox"/> knees <input type="checkbox"/> other
<b>Skin</b> <input type="checkbox"/> skin conditions	<b>Infections</b> <input type="checkbox"/> hepatitis <input type="checkbox"/> skin conditions <input type="checkbox"/> TB	<b>What is your general health status?</b> _____ _____

<b>Current Medications:</b> Condition it treats: _____ Surgery: _____ Date: _____ Nature: _____ Injury: _____ Date: _____ Nature: _____	<b>Primary Care Physician:</b> Address: _____ Present Involvement in Other Health care: <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, please specify: _____
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**Other Medical Conditions (e.g. digestive conditions, gynaecological conditions, hemophilia, etc.):**

**Of Special Note:(presence of internal pins, wires, artificial joints, special equipment):**