# 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 me know as soon as possible. All information gathered for this treatment is confidential except to aid in health issue discovery and/or appropriate treatment. You will be asked to provide written authorization for release of any information where needed.

**Name:**_____ **Date**:_____
**Male/Female** (please circle) **Tel (home)**_____
**Address:**_____ **Business:**_____
**Postal Code**:_____ **E-mail:**_____
**Date of Birth** (yyyy/mm/dd)_____ **Occupation**:_____
**What is your primary complaint:**_____
**How did you hear about us?**_____ **Who referred you?**_____
**Emergency Contact:**_____ **Emergency Phone**:_____

Health History: Please indicate conditions you are experiencing or have experienced

**Respiratory:**
__ chronic cough
__shortness of breath
__bronchitis/asthma
__sinus infection
__emphysema

**Cardiovascular**
__high or low blood pressure
__cold hands or feet
__CCHF or heart attack
__excessive fatigue
__phlebitis or varicose veins
__stroke/CVA
__pacemaker or similar device
__swelling in hands or feet

**Skin**
__rash/open sores/warts
__sensitivity/skin allergies
__contagious skin disease

**Women**
__pregnant (due date:_____)
__painful menstruation

**Digestive:**
__constipation or diarrhea
__nausea or vomiting
__ulcers/blood in stool
__liver or kidney problems
__rapid weight gain or loss

**Other conditions**
__loss of sensation
__diabetes (type___;onset_____)
__allergies (anaphylaxis)
__epilepsy
__cancer
__arthritis
__hypoglycemic
__other:_____

**Head/Neck**
__vision problems or loss
__hearing loss
__dizziness/lightheaded

**Infections:**
__skin conditions
__tuberculosis
__HIV
__hepatitis
__hip or flank pain

**Soft tissue/joint/nerve discomfort and its nature**
__tension/migraine headaches
__fibromyalgia
__multiple sclerosis
__osteo/rheumatoid arthritis
__herniated disc(s)/degenerating
__osteoporosis
__ringing in ears
__tooth/jaw/ear pain
__fractures (where:_____)
__insomnia
__thoracic outlet syndrome
__head trauma concussion

**Muscle Pain/stiffness/injury:**

Please circle areas that are affected below and indicate left(L) / right(R)
**Neck:** L/R **Shoulders:** L/R **Arms:** L/R **Back:** L/R **Legs:** L/R **Feet:** L/R

__bursitis, __tendonitis, __sports/work related injury (date_____), __repetitive sports injury, __whiplash/car accident (date:_____), __carpal tunnel syndrome, __sciatica

**Primary Care Physician**:_____ **Address/Phone**:_____
**Current Medications**:_____ **Condition(s) it treats**:_____
**Surgery**:_____ Date:_____ **Nature of surgery**:_____

Other Medical conditions (i.e. Digestive conditions, gynaecological conditions, haemophilia, etc.)
_____

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

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 a substitute for medical examination or diagnosis, and that it is recommended that I see a Medical Doctor for that service.

I understand that I need to give 24 hours notice for cancellations of appointments. This courtesy keeps bookings open for others to be treated.
Thank you for taking the time to fill out this important Confidential Health History Form.

**Client Signature:_____** **Date:_____**

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***Use this diagram to indicate areas of pain, discomfort, injury or concern:***

Ⓟ = Pain

* = Tender Point

≈ = Spasm

≡ = Tightness

→ = Numbness/tingling

● = Inflammation