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WHERE THE EMPHASIS IS ON YOU!

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### Health History Form

FYI: an accurate health history ensures that it is safe for you to receive a massage treatment, and helps the therapist determine a proper treatment plan. When your health status changes in the future, please let us know. All information gathered on this form is confidential. Your written authorization is legally required before any of this information can be released.

#### Personal Information

Name: \_\_\_\_\_ Date: \_\_\_\_\_  
Address: \_\_\_\_\_ City: \_\_\_\_\_ Postal Code: \_\_\_\_\_  
Home Phone: \_\_\_\_\_ Work Phone: \_\_\_\_\_ Occupation: \_\_\_\_\_  
Date of Birth: \_\_\_\_\_ Email: \_\_\_\_\_ Height: \_\_\_\_\_ Weight: \_\_\_\_\_  
Doctor: \_\_\_\_\_ Phone: \_\_\_\_\_ May I contact? Yes No  
Emergency Contact Name: \_\_\_\_\_ Phone: \_\_\_\_\_

Have you had a massage before? Yes No For relaxation or other reason?: \_\_\_\_\_  
Current Medications: \_\_\_\_\_  
Previous Major Illnesses, Operations: \_\_\_\_\_  
Accidents (please give dates): \_\_\_\_\_  
Other Medical Conditions (e.g. hemophilia, diabetes): \_\_\_\_\_  
Family history (major illnesses, operations): \_\_\_\_\_

Please indicate all conditions you have experienced. Mark C for current or P for past.

#### Joint/Soft Tissue Discomfort:

- Arms
  - Upper Back
  - Mid Back
  - Lower Back
  - Degenerative Discs
  - Feet
  - Hands
  - Hips
  - Jaw
  - Knees
  - Legs
  - Neck
  - Osteo Arthritis
  - Rheumatoid Arthritis
  - Sciatica/Limitation of Movement
  - Shoulders
- in which joints: \_\_\_\_\_  
Other \_\_\_\_\_

#### General Symptoms:

- Fainting
- Dizziness
- Loss of Sleep
- Fatigue
- Nervousness
- Sudden Weight Loss/Gain
- Numbness
- Tingling
- Paralysis
- Headaches (Tension)
- Migraines

#### Cardiovascular:

- High Blood Pressure
- Low Blood Pressure
- Coronary Heart Disease
- Heart Attack
- Phlebitis

#### Infectious:

- Hepatitis
- Tuberculosis
- Human Immunodeficiency Virus (HIV)
- Herpes
- Cold
- Flu
- Athlete's Foot
- Warts
- Other \_\_\_\_\_

#### Digestive:

- Poor Appetite
- Belching/Gas
- Constipation
- Diarrhea
- Nausea
- Ulcer
- Vomiting

(continued on reverse)

Client Name: \_\_\_\_\_

