MASSAGE THERAPY HEALTH HISTORY FORM

An accurate health history is important to ensure that it is safe for you to receive treatments. If your health status changes, please let us know. All information collected is confidential, except as required or allowed by law or to facilitate diagnosis or treatment.

PERSONAL HISTORY

DATE: DD / MM / YYYY

FIRST NAME _____ LAST NAME _____

ADDRESS _____ CITY _____ POSTAL CODE _____ DATE OF BIRTH (DD / MM / YYYY) _____

( ) HOME PHONE _____ ( ) MOBILE PHONE _____ EMAIL ADDRESS _____

EMPLOYER INFORMATION

EMPLOYER _____ OCCUPATION _____

ADDRESS _____ CITY _____ POSTAL CODE _____ ( ) WORK PHONE _____

HOW DID YOU HEAR ABOUT OUR OFFICE?

☐ Internet (Google, Website) ☐ Phone Book ☐ Massage Therapist ☐ Friend / Family _____

☐ Brochure ☐ Medical Doctor ☐ Personal Trainer ☐ Other _____

PREVIOUS MASSAGE THERAPY ☐ YES ☐ NO

THERAPISTS NAME _____ DATE OF LAST VISIT (APPROX.) (DD / MM / YYYY) _____

CLINIC NAME _____

DO YOU WEAR FOOT ORTHOTICS ☐ YES ☐ NO

HOW LONG HAVE YOU WORN THEM? _____ HOW LONG SINCE LAST PAIR? _____

MADE BY _____

PRIMARY CARE MEDICAL DOCTOR

I authorize Target Therapeutics to send a report. ☐ **YES** ☐ **NO** **INITIAL** _____

DOCTORS NAME _____ CITY _____

CHIROPRACTOR ☐ YES ☐ NO

I authorize Target Therapeutics to send a report. ☐ **YES** ☐ **NO** **INITIAL** _____

DOCTORS NAME _____ CLINIC NAME _____

PAST MEDICAL HISTORY (Please indicate conditions you are experiencing and/or experienced.)

GENERAL

☐ Numbness/Tingling ☐ Asthma
☐ Sinus Problems ☐ Cancer
☐ Loss of Sensation ☐ Fever
☐ Vision Loss ☐ Sweats
☐ Blurred Vision ☐ Fainting
☐ Eye Pain ☐ Diabetes
☐ Hearing Loss ☐ Allergies
☐ Earache ☐ Epilepsy
☐ Headache

MUSCLES & JOINTS

☐ Stiffness ☐ Shoulder Pain
☐ Weakness ☐ Osteoporosis
☐ Arthritis ☐ Upper Back
☐ Back Pain ☐ Low Back
☐ Neck Pain ☐ Mid Back
☐ Knee Pain ☐ Swollen Joints
☐ Arm Pain ☐ Other
☐ Leg Pain _____

RESPIRATORY

☐ Chronic Cough ☐ Emphysema
☐ Chest Pain ☐ Chronic Bronchitis
☐ Asthma

INFECTIONS

☐ Hepatitis ☐ Skin Conditions
☐ TB ☐ Other
☐ HIV _____

GASTROINTESTINAL

☐ Indigestion
☐ Nausea
☐ Diarrhea
☐ Colitis
☐ Poor Appetite
☐ Excessive Gas
☐ Constipation
☐ Ulcers

CARDIOVASCULAR

☐ Heart Disease
☐ Poor Circulation
☐ Swelling in Ankles
☐ High Blood Pressure
☐ Low Blood Pressure
☐ Heart Attack
☐ Phlebitis
☐ Stroke/CVA
☐ Pacemaker
☐ Varicose Veins

Please specify any other medical conditions you may have that are not listed: _____

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

Had an accident? ☐ **YES** ☐ **NO** If **YES**, please describes: _____

Had an operation? ☐ **YES** ☐ **NO** If **YES**, please describes: _____

Had a fracture? ☐ **YES** ☐ **NO** If **YES**, please describes: _____

Been hospitalized? ☐ **YES** ☐ **NO** If **YES**, please describes: _____

Do you exercise regularly? ☐ **YES** ☐ **NO** If **YES**, how often: _____

MEDICATION / SUPPLEMENTS

☐ Anti-inflammatory ☐ Blood Pressure ☐ Other: _____
☐ Antibiotics ☐ Depression _____
☐ Cholesterol ☐ Pain Killers _____
☐ Anti-anxiety ☐ Blood Thinners _____
☐ Muscle Relaxants ☐ Vitamins/Herbs _____
☐ Antacids ☐ Essential Fats _____

STRESS LEVELS

☐ **LOW**
☐ **MODERATE**
☐ **HIGH**

MASSAGE THERAPY HEALTH HISTORY FORM

CURRENT HEALTH CONDITION

Primary Complaint (Reason for coming in): _____

Other Doctors or Therapists for this condition: ☐ **YES** ☐ **NO** If **YES**, who treated you: _____

What was the treatment and result: _____ When did this condition begin: _____

Has it occurred before: ☐ **YES** ☐ **NO** If **YES**, when: _____ How many times: _____

Is it: ☐ Job Related ☐ Car Related ☐ Home Related ☐ Stress Related ☐ Injury ☐ Other: _____

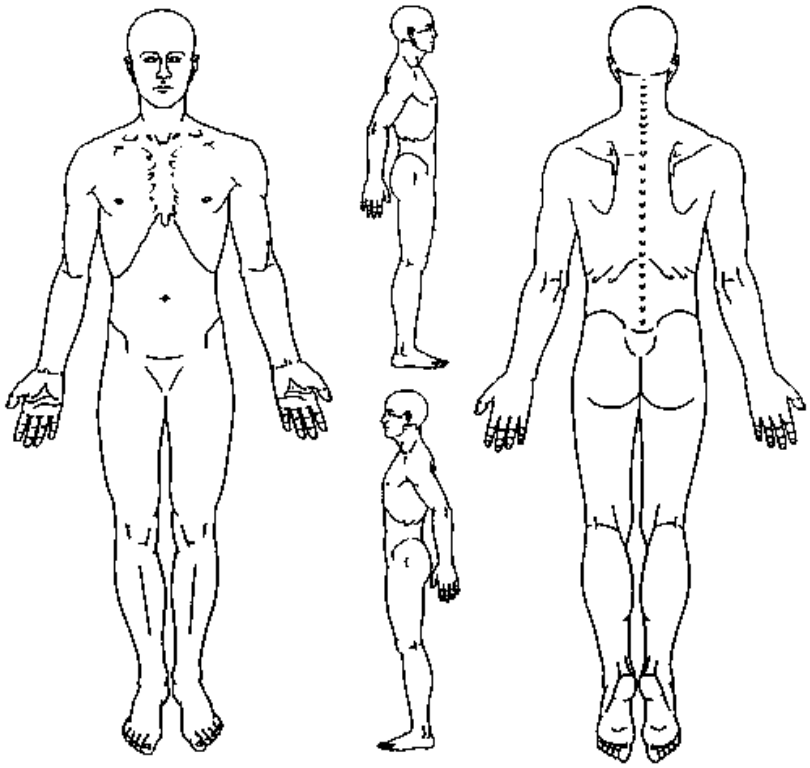
Is the pain getting: ☐ Worse ☐ Better ☐ Constant ☐ Comes and Goes ☐ Other: _____

What aggravates your condition?			**What makes you feel better?**		
☐ Sitting	☐ Lifting	☐ Heat	☐ Sitting	☐ Lifting	☐ Heat
☐ Standing	☐ Lying	☐ Cold	☐ Standing	☐ Lying	☐ Cold
☐ Bending	☐ Walking	☐ Other: _____	☐ Bending	☐ Walking	☐ Other: _____

Please indicate the type(s) of pain you are feeling: ☐ Sharp ☐ Achy ☐ Numb ☐ Burning ☐ Tightness

Please circle the severity of your pain at this time: NO PAIN **0 – 1 – 2 – 3 – 4 – 5 – 6 – 7 – 8 – 9 – 10** WORST PAIN EVER

On the diagrams below use the symbol(s) and draw the location(s) of your pain: Sharp **o** Achy **X** Numb **+** Burning **^** Tightness **#**



INFORMED CONSENT

I have received an explanation of the proposed massage treatment including goals, techniques, benefits, risks, side effects and areas of my body to be treated. I understand I can request modification or termination of treatment at any time. Fees have been explained to me and I have been given an opportunity to ask questions. I give my consent for massage treatment.

_____ DD / MM / YYYY

FULL NAME (PLEASE PRINT) DATE

_____

SIGNATURE