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 | DD / MM / YYYY DATE OF BIRTH

( ) HOME PHONE | ( ) MOBILE PHONE | EMAIL ADDRESS (For Appointment Reminders)

EMPLOYER INFORMATION

EMPLOYER | OCCUPATION

ADDRESS | CITY | POSTAL CODE | ( ) WORK PHONE

HOW DID YOU HEAR ABOUT OUR OFFICE?

☐ Internet ☐ Phone Book ☐ Massage Therapist ☐ Friend / Family _____

☐ Brochure ☐ Medical Doctor ☐ Personal Trainer ☐ Other _____

PREVIOUS MESSAGE THERAPY ☐ YES ☐ NO

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

CLINIC NAME

OTHER PRACTITIONERS SEEN

OSTEOPATHY ☐ Y ☐ N DATE _____

CHIROPRACTOR ☐ Y ☐ N DATE _____

PHYSIOTHERAPY ☐ Y ☐ N DATE _____

ACUPUNCTURE ☐ Y ☐ N DATE _____

OTHER _____ ☐ Y ☐ N DATE _____

PRIMARY CARE MEDICAL DOCTOR

I authorize Target Therapeutics to send a report.

☐ NO ☐ YES INITIAL _____

DOCTORS NAME | CITY

DO YOU WEAR FOOT ORTHOTICS ☐ YES ☐ NO

HOW LONG HAVE YOU WORN THEM? _____

HOW LONG SINCE YOUR LAST PAIR? _____

MASSAGE THERAPY HEALTH HISTORY FORM

PAST MEDICAL HISTORY

GENERAL

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

MUSCLES & JOINTS

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

GASTROINESTINAL

- ☐ 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

INFECTIONS

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

RESPIRATORY

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

- Please specify any other medical conditions you may have that are not listed: _____
- Presence of internal pins, wires, artificial joints, special equipment: _____
- Had an accident? ☐ **YES** ☐ **NO**
  If **YES**, please describe: _____
- Had an operation? ☐ **YES** ☐ **NO**
  If **YES**, please describe: _____
- Had a fracture? ☐ **YES** ☐ **NO**
  If **YES**, please describe: _____
- Been hospitalized? ☐ **YES** ☐ **NO**
  If **YES**, please describes: _____
- Have you had cancer? ☐ **YES** ☐ **NO**
  If **YES**, please describe: _____

MEDICATION / SUPPLEMENTS

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

STRESS LEVELS

- ☐ **LOW**
- ☐ **MODERATE**
- ☐ **HIGH**

MASSAGE THERAPY HEALTH HISTORY FORM

CURRENT HEALTH CONDITION

Primary Complaint (Reason for coming in): _____

Has it occurred before: ☐ **NO** ☐ **YES** _____ 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?

☐ Sitting ☐ Lifting ☐ Heat
☐ Standing ☐ Lying ☐ Cold
☐ Bending ☐ Walking ☐ Other: _____

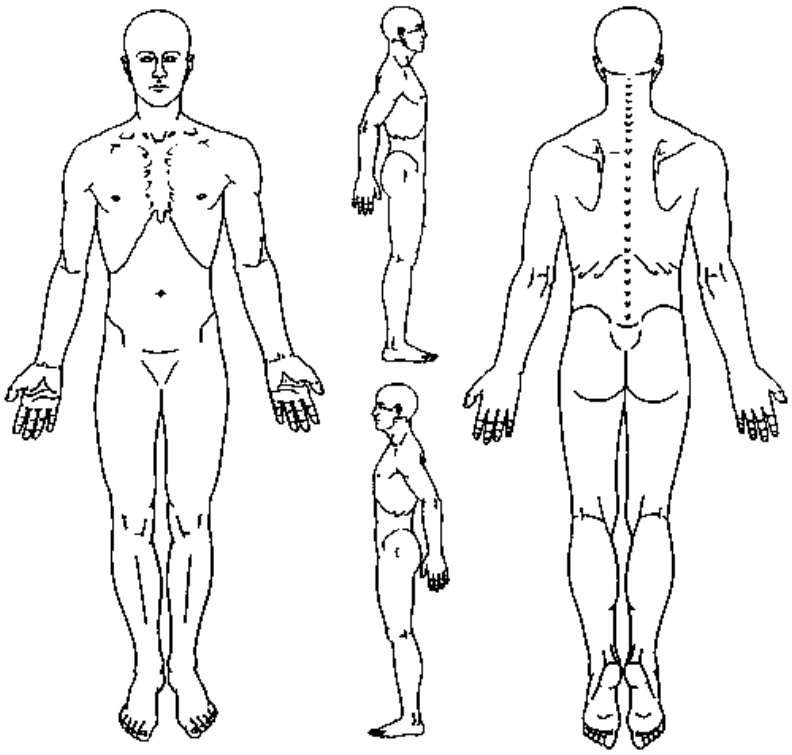
What makes you feel better?

☐ Sitting ☐ Lifting ☐ Heat
☐ Standing ☐ Lying ☐ Cold
☐ 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