**All client information is confidential and written authorization will be obtained prior to the release of any 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 your massage therapy student know.**

## Health History Information – Page 1

Name: _______________________________ Gender/Pronoun _______________________ Date: _____________________________

Address: _________________________________________ Postal Code: _____________ Cell Phone: __________________________

Work Phone: _______________________ Email ________________________________ Birth date: ___________________________

Age: ___________ Height ______________ Weight _____________ Referred by: ___________________________________________

Occupation/Area of Study: ___________________________________________________________ Hours per week: ______________

Recreational Activities: _____________________________________________________________________________________________

_____________________________________________________________________________________________________________

Family Physician: ______________________________ Physician Phone Number: ___________________________________________

Health Care: □ Chiropractor, □ Physiotherapist, □ Acupuncturist, □ Osteopath, □ Naturopath, □ Pedorthist Other_____________________

What is Your Opinion of Your Over-all Health: Excellent / Good / Fair / Poor

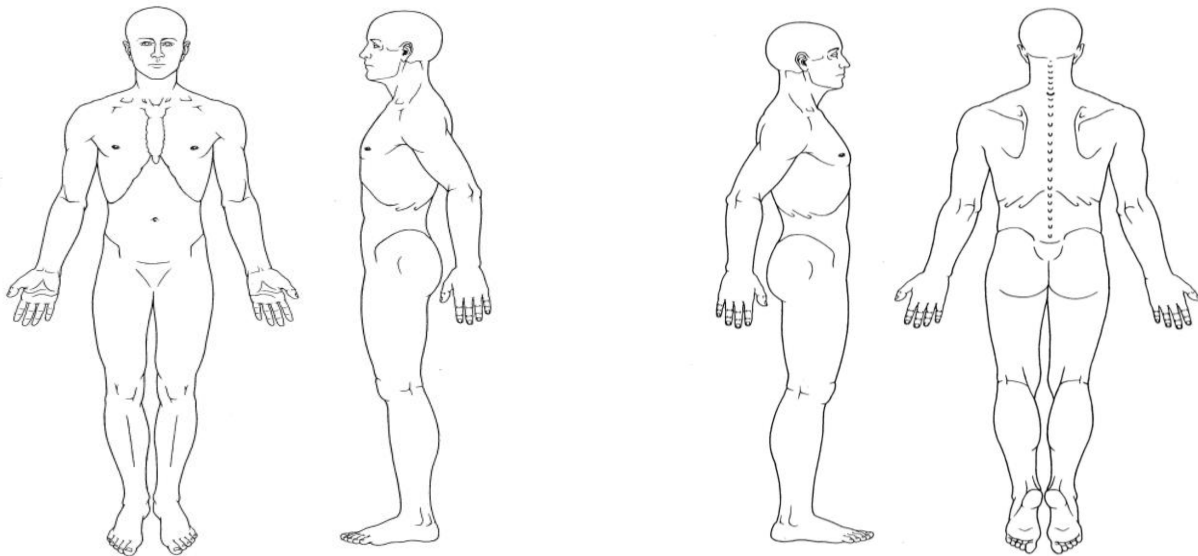
Emergency Contact's Name: _____________________________________ Emergency Contact's Phone: _________________________

Reason for seeking Massage Therapy: □ Relaxation □ Treatment: please state your condition here:______________________________

_____________________________________________________________________________________________________________

What have you tried for relief? Heat □, Cold □, Exercise □, Other □ _____________________________________________________

Locate on the chart areas of pain and/or discomfort



# Health History Information pg 2

Please indicate conditions you are experiencing, or have experienced in the past:

**Head / Neck**

☐Vision Impairment
☐Migraines
☐Vertigo/Dizziness
☐Hearing Impairment

**Cardiovascular System**

☐High Blood Pressure: _____/_____
☐Low Blood Pressure: _____/_____
☐Pacemaker
☐Heart Disease / Condition
☐Varicose Veins
☐Diabetes (onset______)
☐Phlebitis
☐Stroke / CVA
☐Edema
☐Chronic Congestive Heart Failure
☐Poor Circulation

**Nervous System**

☐Sensory Loss
☐Numbness/Tingling
☐Sciatica
☐MS
☐Parkinsons
☐Seizures
☐Paralysis
☐Anxiety
☐Depression
☐Mental Health – Type:__________

**Respiratory System**

☐Asthma
☐Bronchitis
☐Breathing Difficulties
☐Tuberculosis
☐Emphysema
☐Chronic Cough
☐Smoker

**Immune System**

☐Allergies – Type: ____________
☐Hay fever
☐Sinusitis
☐Frequent Colds
☐

**Motor Vehicle Incident: Y N**

**Date** _________________________

**Musculoskeletal:**

☐Arthritis OA or RA
☐Bursitis
☐Tendonitis
☐Whiplash
☐Tension Headaches
☐Fractures
☐Dislocations
☐T.M.J.D.
☐Carpal Tunnel R / L
☐Muscular Pain
☐Muscular Weakness
☐Muscle Joint Stiffness
☐Swollen Joints

**Skin**

☐Rashes/Eruptions
☐Sensitive
☐Bruise Easy
☐Eczema
☐HSV-1 Cold Sores
☐HSV- 2
☐Contagious conditions
☐Lyme disease

**Urinary Tract**

☐Kidney Stones
☐Frequent Infections

**General**

☐Fatigue
☐Hepatitis
☐Cancer
☐Plates, Pins, Screws
☐Fibromyalgia
☐Left handed ☐Right handed

**Surgery / Hospitalization (type/date):**

_______________________________
_______________________________
_______________________________
_______________________________

**Cosmetic Procedures: (type/date):**

_______________________________
_______________________________
_______________________________

**Gastrointestinal**

☐Constipation
☐Liver/Gallbladder
☐Heartburn
☐Ulcers
☐Indigestion
☐Nausea
☐Frequent Vomiting
☐Abdominal Pain
☐Diverticulitis
☐Colitis

**Endocrine**

☐Thyroid Problems
☐Diabetes

**Reproductive**

☐PMS issues
☐Menopause
☐Endometriosis
☐Pelvic Inflammatory Disease
☐Fibroids, Cysts
☐Mastectomy
☐ Recent Childbirth
☐Pregnant
# of weeks_______
# of children______

**Other information (yes or no)**

Previous Massage Experience **Y N**
Good Sleeping habits **Y N**
Hours per night ____________
Insomnia **Y N**
Regular Exercise **Y N**
Regular Eating Habits **Y N**

**Any other conditions:**

___________________________________
___________________________________

**Current Medication(s) & what it treats**

___________________________________
___________________________________
___________________________________
___________________________________

**Please initial if you are not currently taking medications:** ___________

I have answered the above to the best of my knowledge and all information is accurate and current.

Signature: __________________________________________________