The Natural Approach
Massage Therapy and Wellness Centre

Massage Health History Form

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 us know. All the information gathered for this treatment is confidential, except as required or allowed by law, or except to facilitate diagnosis (assessment) or treatment. You will be asked to provide written authorization for release of any information.

Name: ______________________________ Date: ______________________________ (DD/MM/YY)

Street Address: ______________________________ City: ______________________________

Province: ______________________________ Postal Code: ______________________________

Home Phone: ____________________ Work: ____________________ Cell: ____________________

Date of Birth: __________ (DD/MM/YY) Occupation: ____________________ Who referred you? ____________________

Primary Complaint ____

Have you had massage therapy before? If yes, to what extent? ______________________________

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

Respiratory
- □ Chronic cough
- □ Shortness of breath
- □ Bronchitis
- □ Asthma
- □ Emphysema
- □ Family history of respiratory difficulties

Cardiovascular
- □ High blood pressure
- □ Low blood pressure
- □ CCHF (Congestive heart failure)
- □ Heart attack
- □ Phlebitis/varicose veins
- □ Stroke/CVA
- □ Pacemaker/similar device
- □ Heart disease
- □ Family history of cardiovascular difficulties

Other conditions
- □ Loss of sensation
- □ Diabetes (onset: ______________)
- □ Allergies/hypersensitivity
- □ Epilepsy
- □ Cancer
- □ Arthritis/family history of
- □ Skin conditions

Head/Neck
- □ Vision problems
- □ Vision loss
- □ Ear problems
- □ Hearing loss
- □ History of headaches/migraines

Infections
- □ Hepatitis
- □ TB
- □ HIV
- □ Infectious skin/respiratory conditions

Women
- □ Pregnant (due: ________________)

Soft tissue/joint discomfort and its nature
- □ Neck ______________________
- □ Low back ______________________
- □ Mid back ______________________
- □ Upper back ______________________
- □ Shoulders ______________________
- □ Arms ______________________
- □ Legs ______________________
- □ Knees ______________________
- □ Other ______________________

What is your general health status?

____

Current medications: ______________________ Primary care physician: ______________________

Condition it treats: ______________________ Address: ______________________

Surgery: ______________ Date: __________ (DD/MM/YY) Present involvement in other healthcare: □ Yes □ No

Nature: ______________________ If yes, please specify: ______________________

Injury: ______________ Date: ______________ ______________________

Other medical conditions (e.g. digestive conditions, gynecological conditions, hemophilia conditions, etc.):

____

Of special note: (presence of internal pins, wires, artificial joints, special equipment):

____

Patient Signature: ______________________________ Date: ______________________ (DD/MM/YY)

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