Health History Form

Name: _______________________________ Phone: _______________________________

Address: ____

Occupation: ___________________________ Date of Birth: _________________________

Email address:____

Have you received Massage before? Yes ☐ No ☐ When? __________________________

Did you receive a referral for massage? Yes ☐ No ☐

Please list the source of referral: ____

Family Doctor: ______________________ Address: ________________________________

Please list any condition you are experiencing or have experienced in the past:

☐ high blood pressure
☐ Low blood pressure
☐ varicose vein/phlebitis
☐ heart problem : ________________
☐ stroke/CVA
☐ artificial heart valve/pacemaker*

☐ hepatitis, type: _________________
☐ Herpes
☐ skin condition: _________________
☐ TB
☐ HIV

☐ loss of sensation, where:________________
☐ tingling, shooting pain, where: ____________
☐ sciatica R/L

☐ Asthma
☐ Bronchitis
☐ Emphysema
☐ Shortness of breath

☐ diabetes, type I or II
☐ bursitis, where: _________________
☐ epilepsy
☐ fibromyalgia
☐ arthritis, RA or OA, onset:________________
☐ family history of arthritis
☐ internal wires, pins, or artificial joints or
Where : _______________________

☐ Allergies, to what:________________
☐ Tendinitis, where: ________________
☐ Cancer
☐ Degenerative disc disease
☐ Pregnancy, due date:______________
☐ Gynaecological condition
☐ Migraine special equipment
☐ Headache

☐ And other condition not mentioned: ____

What is your Primary Complaint?

____

____

Current Involvement of treatment with other Health Care Providers:

____

Please list all medication and reason for use:

____

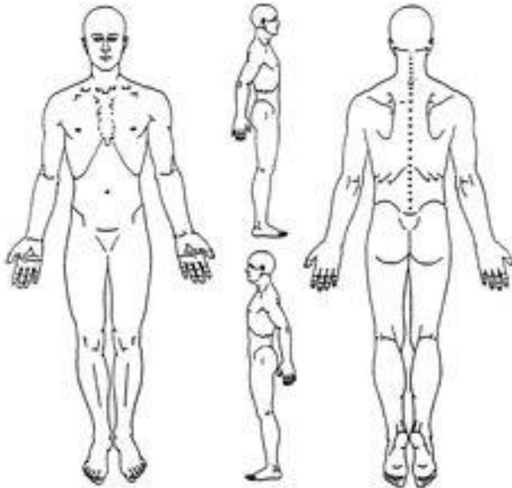
____

Please list previous injuries or surgeries:

____

____

Please indicate your pain on the picture below:



I verify the information on this form represents my past and current health status. I hereby consent for my therapist to treat me with massage therapy for the above noted purposes including such assessments, examinations and techniques, which may be recommended, by my therapist. I acknowledge that the therapist is not a physician and does not diagnose illness or disease or any other physical or mental disorder. I clearly understand that massage therapy is not a substitute for medical examination.

Signature: _______________________________________ Date: _________________________

Date of initial Health History: _______________________

Date of Update 1: ________________________________

Date of Update 2: ________________________________

Date of Update 3: ________________________________