Massage Therapy Health History

Please print clearly.

Name _____ Date of Birth_____

Address:_____City: _____ Prov._____

Postal Code:_____Cell Number_____ Home_____Work _____

Email Address _____ Occupation_____

Emergency Contact _____Contact number_____

Cardiovascular

___High blood pressure
___Low blood pressure
___Chronic congestive heart failure
___Heart Attack
___Phlebitis / Varicose veins
___Stroke / CVA
___Pacemaker or similar device
___Heart disease
___Dizziness / Vertigo
___Seizure

Respiratory

___Asthma
___Bronchitis
___Emphysema
___Chronic Cough
___Shortness of breath

Digestive

___ Constipation
___Crohn's Disease
___Colitis
___irritable bowel syndrome
___Ulcers

Accident/Injury

__ Motor Vehicle Accident: When _____
__ Injury: What_____
__ Concussion
__ Scars / Surgery_____
__ Fractures_____

Other health conditions: _____

Head and Neck

___History of headaches
___History of migraines
___Vision problems
___Vision loss
___Ear problems
___Hearing loss

Infectious Conditions

__Eczema
__ Psoriasis
__ Rash
__ Warts
__ Open sores
__ HIV

Muscle / Joint

___ Neck
___ Back (lower)
___ Back (mid)
___ Back (upper)
___ Shoulders (Rt) (Lt)
___ Elbows (Rt) (Lt)
___ Wrist / Hand (Rt) (Lt)
___ Hips (Rt) (Lt)
___ Knees (Rt) (Lt)
___ Ankle / Foot (Rt) (Lt)
___ Spine

Other

Loss of sensation ?
Where? _____
___Diabetes : Type_____
_ __Allergies
___Epilepsy
___Cancer
___Arthritis
___Hemophililia
___Fibromyalgia
___Chronic Fatigue
___ Scoliosis
___Osteoporosis

I acknowledge that I am responsible for all costs incurred for treatment services. **Please initial**: _____

I agree and understand that **24-hour cancellation notice of appointment is required.** Failure to provide this will result in the full cost of massage appointment. **Please initial_____**

Signature: _____ Date:_____