Health History Form

An Accurate health history is important to ensure that it is safe for you to receive a massage treatment. All information gathered for this treatment is confident except as required or allowed by law. Written authorization will be required for release of any information.

A 24-hour cancellation notice is required otherwise a missed appointment fee will be charged. This form must be updated annually.

First Name:	Last Name:

Health History: Please Indicate with checking of the box the conditions you are experiencing past or present.

Soft Tissue/Joints

(Specify its nature: Pain, Stiffness, Numbness, Twitching, etc.

	Present	Past
☐ Neck		
☐ Shoulder		
☐ Upper Back		
☐ Mid Back		
☐ Low Back		
☐ Arms		
☐ Chest		
☐ Legs		
☐ Knees		
☐ Hips		
☐ Other		

Respiratory

- ☐ Chronis Cough
- ☐ Shortness of Breath
- ☐ Bronchitis
- ☐ Asthma
- ☐ Emphysema
- ☐ Pneumonia
- ☐ Sinus Problems
- ☐ Family history of any of the above

Skin

- ☐ Skin condition: Specify__
- ☐ Bruise easily
- ☐ Herpes
- ☐ Varicose Veins
- ☐ Athletes Foot
- ☐ Loss of Sensation

Infection Disease

- ☐ Hepatitis
- ☐ Infections Skin Conditions
- ☐ Tuberculosis
- ☐ HIV
- ☐ Other:_____
- ☐ Family History of any of the above

History Headaches

- ☐ Tension
- ☐ Migraines
- ☐ Tooth/Jaw/Ear Pain
- ☐ Head Trauma/Date:_____
- ☐ History of Headaches/Type:__
- ☐ Other:_____

Cardiovascular

- ☐ High Blood Pressure
- ☐ Low Blood Pressure
- ☐ Hearth Attack/Date:_____
- ☐ Phlebitis/DVT
- ☐ Stroke/CVA/Date:__
- ☐ Pulmonary Emboli
- ☐ Pacemaker
- ☐ Heart Disease
- ☐ Angina
- ☐ Chronic Congestive Heart Failure
- ☐ Family History of any of the above

Infection Disease

- ☐ Hepatitis
- ☐ Infectious Skin Conditions
- ☐ Tuberculosis
- ☐ HIV
- ☐ Other:_____

Gastrointestinal

- ☐ Irritable Bowl Syndrome
- ☐ Colitis
- ☐ Gastroenteritis
- ☐ Chron's Disease
- ☐ Constipation
- ☐ Family history if any of the above

Mental Health

- ☐ Depression
- ☐ Anxiety
- ☐ PTSD
- ☐ Other(phobias,manic,etc:____

Other Conditions

- ☐ Neurological Conditions:____
- ☐ Epilepsy
- ☐ Diabetes/Onset:_____
- ☐ Allergies:_____
- ☐ Family History Allergies
- ☐ Family History Hypersensitivities
- ☐ Cancer:_____
- ☐ Arthritis:_____
  Type OA/RA/Other:_____
  Where:_____
- ☐ Family History of Arthritis
- ☐ Vision Loss
- ☐ Hearing Loss
- ☐ Insomnia
- ☐ Hemophilia
- ☐ Kidney/Bladder problems
  Dialysis? Y N
- ☐ Overactive Bladder
- ☐ Osteopenia
- ☐ Osteoporosis
- ☐ Positional Vertigo
- ☐ Family history of any of the above:_____
- ☐ Other:_____

Smoker

- ☐ Yes
- ☐ No

Please continue on back of page

Women

- ☐ Pregnant/Due Date:_____
- ☐ Gynecological Conditions:_____
- ☐ Breast Pain
  Cysts
  Breast Lift: Date _____/_____/_____
  Breast Augmentation(date)
  _____/_____/_____
  Breast Reduction(date)
  _____/_____/_____
- ☐ Menopause
- ☐ Hysterectomy(date)
  _____/_____/_____

Accident/Injury

- ☐ Car Accident Work Related?
  Yes No
- ☐ Date:_____
- ☐ Symptoms:_____
- ☐ Physical Limitations:_____

Surgery

- ☐ Type:_____
- ☐ Date:_____
- ☐ Current Symptoms:_____

Current Medications

_____

_____

_____

Other

- ☐ Present Involvement in other Health Care: Yes / No
  If Yes, please specify:_____
- ☐ Pins/Wires/Prosthetics:_____
- ☐ Medical Alert Bracelet (specify condition/allergy)

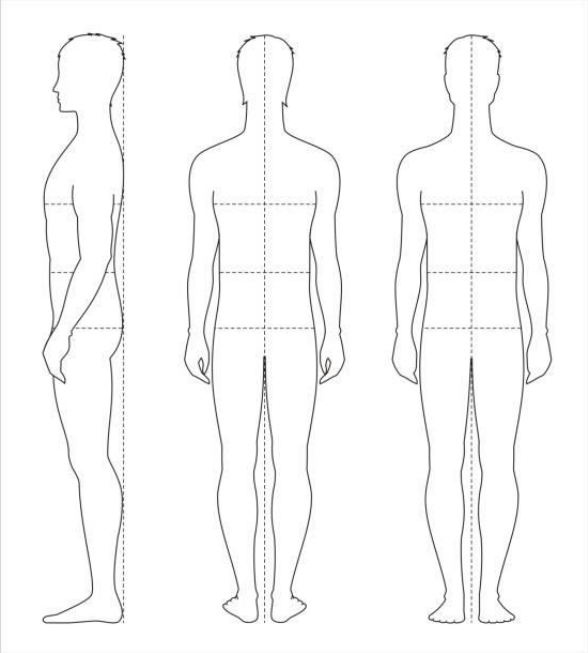
  _____

  _____

Signature:_____

Date:_____

(Chart for Therapists use only)
Circle problem area(s)



Date: _____

Updated **Client Signature**: _____

Consent for Assessment and Treatment of Sensitive Areas

I, _____(name), have requested assessment and/or treatment by this Registered Massage Therapist (RMT)_____(name) for treatment of the clinically relevant areas indicated below (please initial)

_____Buttocks (gluteal Muscles)
_____Chest Wall Muscles
_____Upper Inner Thigh(s)
_____Breast(s)

The RMT has explained the following to me and I fully understand the proposed assessment and/or treatment:

- The nature of the assessment, including the clinical reason(s) for assessment of the above area(s) and the draping methods to be used
- The expected benefits of the assessment
- The potential risks of the assessment
- The potential side effects of the assessment
- That consent is voluntary
- That I can withdraw or alter my consent at anytime

I voluntary give my informed consent for the assessment and/or treatment discussed and outlined above.

Client Name (print): _____

Client Signature: _____ Date: _____

Ongoing Treatment:

I am aware that the treatment of the above indicated area(s) is part of a treatment plan which has been discussed with me by my RMT. I confirm that, on the following date(s), the RMT has reviewed the treatment plan and I provide my informed consent

Client Signature: _____ Date: _____

Client Signature: _____ Date: _____