MASSAGE THERAPY
HEALTH HISTORY FORM

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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 me know.

Date (MM/DD/YY): ______________________

Name:	______________	**Cell Phone:**	______________
Address:	______________	**Home Phone:**	______________
	______________	**Business Phone:**	______________
Date of Birth (MM/DD/YY)	______________	**Email Address:**	______________
Current Age:	______________	**Occupation:**	______________
Current Medications:	______________	**Primary Physician:**	______________
Condition it treats:	______________	**Their Address:**	______________
Surgery (if applicable):	______________	**Their Telephone:**	______________
Date and Nature:	______________	**Emergency Contact:**	______________
Injury (if applicable):	______________	**Relationship:**	______________
Date and Nature:	______________	**Phone Number:**	______________
Who referred you?	______________		

What is your primary complaint (reason for seeking treatment)? ______________

Are you seeing any other health care specialists? Yes ( ) No ( ) If yes, please specify: ______________

Other Medical conditions (e.g. Digestive conditions, gynecological, hemophilia etc): ______________

Of Special Note: (presence of internal pins, wires, artificial joints, special equipment): ______________

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

Respiratory
__ Chronic cough
__ Shortness of breath
__ Bronchitis
__ Asthma
__ Emphysema

Cardiovascular
__ High blood pressure
__ Low blood pressure
__ CCHF
__ Heart attack
__ Phlebitis
__ Stroke/CVA
__ Pacemaker or similar device

Skin
__ Skin conditions

Other conditions
__ Loss of sensation
__ Diabetes (onset ___________________)
__ Allergies (i.e. anaphylaxis or
or skin irritation
__ Epilepsy
__ Cancer
__ Arthritis

Head/Neck
__ Vision problems, vision loss
__ Headaches tension/migraines
__ Ear problems
__ Hearing loss

Infections
__ Hepatitis __ TB __ HIV

Women
__ Pregnant (Due date:__________)

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?
____

Do you have any Family History of any of the above pathologies? If yes, please indicate.
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All 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.

Signature: ______________________________

I give Christine Veres permission to contact me by email. _____