



**MASSAGE THERAPY
HEALTH HISTORY FORM**

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: _____

Address: _____

Date of Birth (MM/DD/YY) _____

Current Age: _____

Current Medications: _____
Condition it treats: _____

Surgery (if applicable): _____
Date and Nature: _____

Injury (if applicable): _____
Date and Nature: _____

Who referred you? _____

Cell Phone: _____

Home Phone: _____

Business Phone: _____

Email Address: _____

Occupation: _____

Primary Physician: _____

Their Address: _____

Their Telephone: _____

Emergency Contact: _____

Relationship: _____

Phone Number: _____

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 | Other conditions |
| <input type="checkbox"/> Chronic cough | <input type="checkbox"/> Loss of sensation |
| <input type="checkbox"/> Shortness of breath | <input type="checkbox"/> Diabetes (onset _____) |
| <input type="checkbox"/> Bronchitis | <input type="checkbox"/> Allergies (i.e. anaphylaxis or skin irritation) |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Epilepsy |
| <input type="checkbox"/> Emphysema | <input type="checkbox"/> Cancer |
| | <input type="checkbox"/> Arthritis |

Cardiovascular

High blood pressure

Low blood pressure

CCHF

Heart attack

Phlebitis

Stroke/CVA

Pacemaker or similar device

Head/Neck

Vision problems, vision loss

Headaches tension/migraines

Ear problems

Hearing loss

| | |
|--|------------------------------------|
| Skin | Infections |
| <input type="checkbox"/> Skin conditions | <input type="checkbox"/> Hepatitis |
| | <input type="checkbox"/> TB |
| | <input type="checkbox"/> 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. _____

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. _____