HEALTH HISTORY FORM

The information request below will assist us in treating you safely. Feel free to ask any questions about the information being requested. Please note that all information provided will be kept confidential unless allowed or required by law. Your written permission will be required to release any information.

Date:______________________

Name:____________________________________ Phone #:____________________________________

Address:____

Occupation:________________________________ Date of Birth:________________________________

Have you received massage therapy or athletic therapy before? Yes______ No______ MT AT (please circle)

Did a health care practitioner refer you? Yes______ No______

If yes please provide their name and contact info: ____

____

Please indicate if you are experiencing or have experienced:

Cardiovascular

___ high blood pressure ___ low blood pressure

___ chronic congestive heart failure ___ heart attack

___heart disease ___pacemaker or similar device

___phlebitis/varicose veins ___ Stroke/CVA

Is there a family history of any of the above? ___yes ___no

Respiratory

___chronic cough ___shortness of breath

___bronchitis ___asthma ___emphysema

Is there a family history of any of the above? ___yes ___no

Current medications:_________________________

____

Condition in treats:__________________________

Are you currently receiving treatment from another health care practitioner? ___yes ___no

For what?________________________________

Injury & date:________________________________

Nature:______________________________________

Surgery & date:_______________________________

Nature:______________________________________

Infections

___hepatitis ___herpes

___skin conditions, what?________________

___TB ___HIV

Other conditions

___loss of sensation? where?

____

___diabetes, onset:_______

Allergies/hypersensitivity to what?

____

Type of reaction:______________

___epilepsy ___arthritis

___cancer, where?_____________

Is there a family history of any of the above? ___yes ___no

Head/Neck

___history of headache

___history of migraine

___vision loss

___ear problems

___hearing loss

Women

___pregnant, due:____________________

___gynaecological conditions, what?

____

Overall how is your general health?

____

Primary care physician & phone #

____

____

Do you have any other medical conditions? ___yes ___no

Do you have any internal pins, wires, artificial joints or special equipment? ___yes ___no

What?______________________________________

Where?_____________________________________

What is your reason for seeking treatment? Please include the location of any tissue or joint discomfort:

____

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