Massage Health History Form

NAME ______________________ DATE ______________________

DATE OF BIRTH ______________________ OCCUPATION ______________________

Have you received massage before? ○ YES ○ NO

Did a health care professional refer you for massage therapy? ○ YES ○ NO

Please indicate conditions you are experiencing or have experienced:

CARDIOVASCULAR

- ○ HIGH BLOOD PRESSURE
- ○ LOW BLOOD PRESSURE
- ○ CHRONIC CONGESTIVE HEART FAILUR
- ○ HEART ATTACK
- ○ PHLEBITIS/VARICOSE VEINS
- ○ STROKE/CVA
- ○ PACEMAKER OR SIMILAR DEVICE
- ○ HEART DISEASE

RESPIRATORY

- ○ CHRONIC COUGH
- ○ SHORTNESS OF BREATH
- ○ BRONCHITIS
- ○ ASTHMA
- ○ EMPHYSEMA

Is there a family history of any of the above conditions? ○ YES ○ NO

INFECTIONS

- ○ HEPATITIS
- ○ SKIN CONDITIONS
- ○ TB
- ○ HIV
- ○ HERPES

HEAD/NECK

- ○ HISTORY OF HEADACHES
- ○ HISTORY OF MIGRAINES
- ○ VISION PROBLEMS
- ○ VISION LOSS
- ○ EAR PROBLEMS
- ○ HEARING LOSS

OTHER CONDITIONS

- ○ LOSS OF SENSATION Where? ______________________
- ○ DIABETES Onset: ______________________
- ○ ALLERGIES - HYPERSENSITIVITY To What? ______________ Type of Reaction: ______________
- ○ EPILEPSY
- ○ CANCER Where? ______________________
- ○ SKIN CONDITIONS What? ______________________
- ○ ARTHRITIS Where? ______________ Is there a history of arthritis? ______________

OVERALL, HOW IS YOUR GENERAL HEALTH? ______________________

Current Medications and Conditions it Treats

Medication ______________________ Condition ______________________

Medication ______________________ Condition ______________________

Medication ______________________ Condition ______________________

Surgeries

Date ______________________ Nature ______________________

Date ______________________ Nature ______________________

Injuries

Date ______________________ Nature ______________________

Date ______________________ Nature ______________________

Date ______________________ Nature ______________________

Any other medical conditions? (eg digestive conditions, hemophilia, osteoporosis)

______________________ ______________________

______________________ ______________________

Chief complaint

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Primary Care Physician

Name ______________________ Phone ______________________

Address ____

ICBC Info

Claim No ______________________ Date of MVA ______________________

Adjuster's Name ______________________ Adjuster's Phone ______________________