MASSAGE MATTERS
HEALTH HISTORY FORM

Name:		Phone:	Alternate:
Address Street/PO Box:	City/Town:	Province:	Postal Code:
Occupation:	Email:		Date of Birth:

Please indicate conditions you are experiencing or have experienced

Cardiovascular ( ) high blood pressure ( ) low blood pressure ( ) CCHF ( ) heart attack ( ) phlebitis/varicose veins ( ) stroke/CVA ( ) pacemaker ( ) heart disease **Respiratory** ( ) chronic cough ( ) shortness of breath ( ) bronchitis ( ) asthma ( ) emphysema	**Infections** ( ) hepatitis ( ) skin conditions ( ) TB ( ) HIV ( ) herpes **Other Conditions** ( ) loss of sensation, where? ____________________________ ( ) diabetes, onset:____________ ( ) allergies/hypersensitivity to what? ____________________ type of reaction:____________ ( ) epilepsy ( ) cancer, where? ____________ ( ) skin conditions, what? ____________________________ ( ) arthritis	**Head/Neck** ( ) history of headaches ( ) history of migraines ( ) vision problems ( ) vision loss ( ) ear problems ( ) hearing loss **Women** ( ) pregnant, due:________________ ( ) gynecological conditions, what? ________________________ Overall, how is your general health? ________________________________ Primary Care Physician: ________________________________ Address: ________________________________

CURRENT HEALTH STATUS

Reason for seeking massage therapy:	**Lifestyle** (regular use) ( ) Exercise regularly ( ) Alcohol & Drugs ( ) Caffeine ( ) Smoke **Other Treatments** ( ) Chiropractic ( ) Physiotherapy ( ) Alternative Therapy
Medications: Reasons for use	

PAST SURGERIES OR INJURIES

(car accidents, major falls, internal pins, wires, artificial joints)

Surgery/Injury	Date	Treatment Received

ADDITIONAL COMMENTS/CONCERNS:

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How did you hear about us?

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- **I understand that the information given will aid my therapist in creating a treatment specific to my needs. I verify that the information given on this form is true and accurately reflects my past and current health status.**
- **I am aware that if I neglect to cancel booked appointments that I am unable to attend, I will be charged half of the treatment cost.**
- **I agree that if my insurance company, for any reason, will not cover my treatments, I will be responsible for paying the full amount.**

__________________________________ __________________________

Signature **Date**