



MASSAGE THERAPY HEALTH HISTORY FORM

An accurate health history is important to ensure that it is safe for you to receive treatments. If your health status changes, please let us know. All information collected is confidential, except as required or allowed by law or to facilitate diagnosis or treatment.

PERSONAL HISTORY				
				DATE: DD / MM / YYYY
FIRST NAME	LAST NAME			
ADDRESS	CITY	POSTAL CODE	DATE OF BIRTH DD / MM / YYYY	
()	()	EMAIL ADDRESS (For Appointment Reminders)		
HOME PHONE	MOBILE PHONE			
EMPLOYER INFORMATION				
EMPLOYER		OCCUPATION		
ADDRESS	CITY	POSTAL CODE	() WORK PHONE	
HOW DID YOU HEAR ABOUT OUR OFFICE?				
<input type="checkbox"/> Internet <input type="checkbox"/> Phone Book <input type="checkbox"/> Massage Therapist <input type="checkbox"/> Friend / Family _____ <input type="checkbox"/> Brochure <input type="checkbox"/> Medical Doctor <input type="checkbox"/> Personal Trainer <input type="checkbox"/> Other _____				
PREVIOUS MESSAGE THERAPY <input type="checkbox"/> YES <input type="checkbox"/> NO	OTHER PRACTITIONERS SEEN			
THERAPISTS NAME _____ DATE OF LAST VISIT (APPROX.) _____ CLINIC NAME _____	OSTEOPATHY <input type="checkbox"/> Y <input type="checkbox"/> N DATE _____ CHIROPRACTOR <input type="checkbox"/> Y <input type="checkbox"/> N DATE _____ PHYSIOTHERAPY <input type="checkbox"/> Y <input type="checkbox"/> N DATE _____ ACUPUNCTURE <input type="checkbox"/> Y <input type="checkbox"/> N DATE _____ OTHER _____ <input type="checkbox"/> Y <input type="checkbox"/> N DATE _____			
PRIMARY CARE MEDICAL DOCTOR	DO YOU WEAR FOOT ORTHOTICS <input type="checkbox"/> YES <input type="checkbox"/> NO			
I authorize Target Therapeutics to send a report. <input type="checkbox"/> NO <input type="checkbox"/> YES INITIAL _____ DOCTORS NAME _____ CITY _____	HOW LONG HAVE YOU WORN THEM? _____ HOW LONG SINCE YOUR LAST PAIR? _____			

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PAST MEDICAL HISTORY

GENERAL

- Numbness/Tingling
- Sinus Problems
- Loss of Sensation
- Vision Loss
- Blurred Vision
- Eye Pain
- Hearing Loss
- Earache
- Headache
- Asthma
- Cancer
- Fainting
- Diabetes
- Epilepsy
- Fever
- Sweats
- Allergies

MUSCLES & JOINTS

- Stiffness
- Weakness
- Arthritis
- Back Pain
- Neck Pain
- Knee Pain
- Arm Pain
- Leg Pain
- Shoulder Pain
- Osteoporosis
- Upper Back
- Low Back
- Mid Back
- Swollen Joints
- Other _____

GASTROINTESTINAL

- Indigestion
- Nausea
- Diarrhea
- Colitis
- Poor Appetite
- Excessive Gas
- Constipation
- Ulcers

CARDIOVASCULAR

- Heart Disease
- Poor Circulation
- Swelling in Ankles
- High Blood Pressure
- Low Blood Pressure
- Heart Attack
- Phlebitis
- Stroke/CVA
- Pacemaker
- Varicose Veins

INFECTIONS

- Hepatitis
- TB
- HIV
- Skin Conditions
- Other _____

RESPIRATORY

- Chronic Cough
- Chest Pain
- Asthma
- Emphysema
- Chronic Bronchitis

• Please specify any other medical conditions you may have that are not listed:

• Presence of internal pins, wires, artificial joints, special equipment:

• Had an accident? YES NO
If YES, please describe:

• Had an operation? YES NO
If YES, please describe:

• Had a fracture? YES NO
If YES, please describe:

• Been hospitalized? YES NO
If YES, please describes:

• Have you had cancer? YES NO
If YES, please describe:

MEDICATION / SUPPLEMENTS

- | | | |
|--|---|---------------------------------------|
| <input type="checkbox"/> Anti-inflammatory | <input type="checkbox"/> Blood Pressure | <input type="checkbox"/> Other: _____ |
| <input type="checkbox"/> Antibiotics | <input type="checkbox"/> Depression | _____ |
| <input type="checkbox"/> Cholesterol | <input type="checkbox"/> Pain Killers | _____ |
| <input type="checkbox"/> Anti-anxiety | <input type="checkbox"/> Blood Thinners | _____ |
| <input type="checkbox"/> Muscle Relaxants | <input type="checkbox"/> Vitamins/Herbs | _____ |
| <input type="checkbox"/> Antacids | <input type="checkbox"/> Essential Fats | _____ |

STRESS LEVELS

- LOW
- MODERATE
- HIGH

MASSAGE THERAPY HEALTH HISTORY FORM

CURRENT HEALTH CONDITION

Primary Complaint (Reason for coming in): _____

Has it occurred before: NO YES _____ How many times: _____

Is it: Job Related Car Related Home Related Stress Related Injury Other: _____

Is the pain getting: Worse Better Constant Comes and Goes Other: _____

What aggravates your condition?

- Sitting Lifting Heat
- Standing Lying Cold
- Bending Walking Other: _____

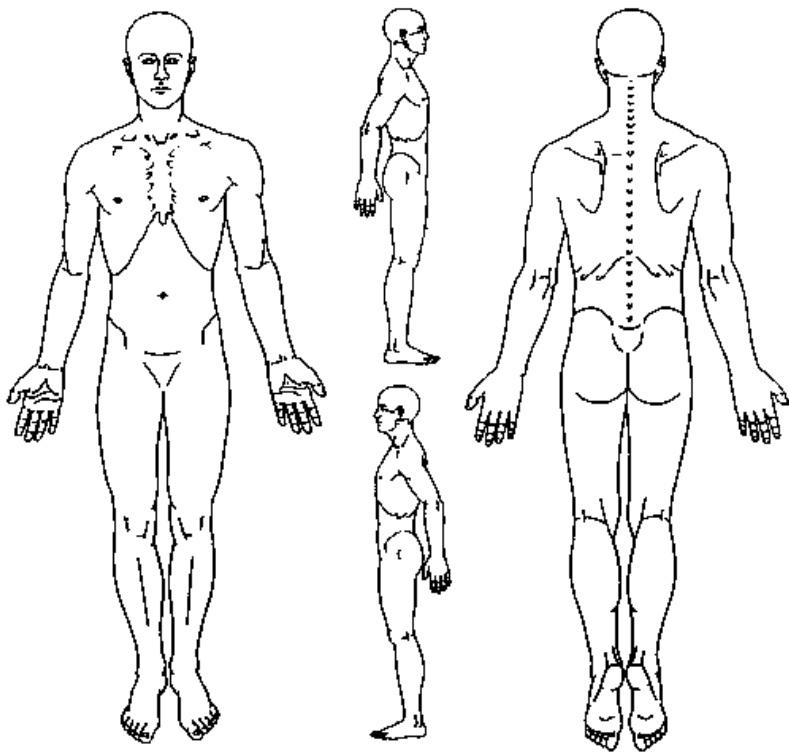
What makes you feel better?

- Sitting Lifting Heat
- Standing Lying Cold
- Bending Walking Other: _____

Please indicate the type(s) of pain you are feeling: Sharp Achy Numb Burning Tightness

Please circle the severity of your pain at this time: NO PAIN 0 - 1 - 2 - 3 - 4 - 5 - 6 - 7 - 8 - 9 - 10 WORST PAIN EVER

On the diagrams below use the symbol(s) and draw the location(s) of your pain: Sharp **○** Achy **X** Numb **+** Burning **^** Tightness **#**



INFORMED CONSENT

I have received an explanation of the proposed massage treatment including goals, techniques, benefits, risks, side effects and areas of my body to be treated. I understand I can request modification or termination of treatment at any time. Fees have been explained to me and I have been given an opportunity to ask questions. I give my consent for massage treatment.

_____ DD / MM / YYYY
 FULL NAME (PLEASE PRINT) DATE

 SIGNATURE