Date: RMT:

REGISTERED MASSAGE THERAPY **HEALTH HISTORY**

PERSONAL INFORMATION

Name:		Age:
Address:	City:	Postal Code:
Home phone:	Cell phone:	Work phone:
E-mail address:	Birth date:	
Occupation:		

Have you received massage therapy before? □ Yes □ No

How did you hear about our clinic? □ Website □ Internet □ Location □ Referral:

Did a health care practitioner refer you for massage therapy? □ Yes □ No

Name**:** City:

Primary care physician: Address:

PLEASE INDICATE CONDITIONS YOU ARE EXPERIENCING OR HAVE EXPERIENCED:

Cardiovascular
- □ high blood pressure
- □ low blood pressure
- □ chronic congestive heart failure
- □ heart attack
- □ phlebitis/varicose veins
- □ stroke/CVA
- □ pacemaker or similar device
- □ heart disease

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

Other Conditions
- □ loss of sensation, location:
- □ diabetes, onset:
- □ allergies, sensitivities:
- □ epilepsy
- □ cancer, type:
- □ skin condition, describe:
- □ arthritis, location:

Is there a family history of arthritis? □ Yes □ No

Head/Neck
- □ history of headaches
- □ history of migraines
- □ vision problems
- □ vision loss
- □ ear problems
- □ hearing loss

Women
- □ pregnant, due:
- □ gynecological conditions, describe:

Infections
- □ hepatitis
- □ TB
- □ HIV
- □ herpes

Overall, how is your general health?

Current medications and conditions they treat:

Are you currently receiving treatment from another health care professional? □ Yes □ No

(Chiropractor, physiotherapist, naturopath, etc.) If yes, describe:

Injuries? (Include dates.)

Surgeries? (Include dates.)

Do you have any other medical conditions? (e.g. digestive conditions, hemophilia, osteoporosis, mental illness)

Describe:

Do you have any internal pins, wires, artificial joints, or special equipment? Describe:

What is the reason you are seeking massage therapy? Please include location of any tissue or joint discomfort.

How would you like to be reminded of your appointment? □ phone □ email

I am aware that 24 hour notice must be given before cancelling/rescheduling an appointment or the full fee will be charged.

1:
2:
3:

Signature: _____