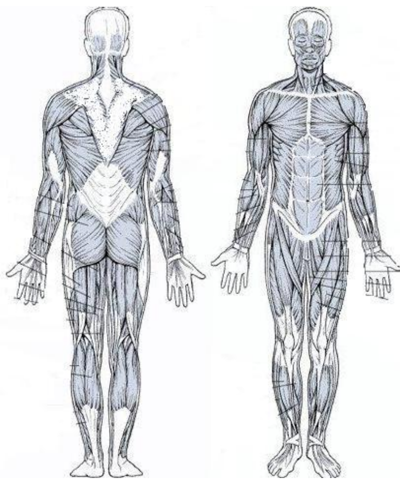
Massage Therapy Health History Form

please print all information

Name: ______________________ **Date:** ______________
Address: ______________________ **City:** ______________
Postal Code: ____________ **Occupation:** ______________
Phone #'s: h) ____________ w) ____________ c) ____________
DOB (d/m/y): ____________ **Age:** ____________
Chiropractor: ______________ **Physician:** ______________

How did you hear about this clinic? ______________________

Main Area of Concern: (please shade)



Why are you coming in today? :

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Have you ever had: (please check √) massage therapy ☐ chiropractic ☐ physiotherapy ☐

Medical History: please check √ if any of the following applies:

☐ headaches or migraine	☐ High/low blood pressure	☐ diabetes
☐ back injury	☐ fainting or dizziness	☐ kidney disease
☐ neck injury	☐ heart disease	☐ Crohn's disease
☐ whiplash	☐ stroke	☐ nervous disorders
☐ shoulder pain	☐ phlebitis/circulatory problems	☐ multiple sclerosis
☐ hip/leg pain	☐ varicose veins	☐ epilepsy
☐ jaw or ear pain	☐ skin conditions	☐ pelvic inflammatory disease
☐ osteoporosis	☐ Fibromyalgia	☐ pregnancy (month)____________
☐ osteoarthritis	☐ asthma/respiratory	☐ HIV
☐ rheumatoid arthritis	☐ cancer	☐ other:________________

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Have you had surgery in the past? If yes, for what? :

Have you had any fractures/sprains in the past? If yes, please describe:

Have you had any serious illness in the past? If yes, please describe:

Did the current injury result from a motor vehicle accident or workplace injury?

Have you had any of the following regarding your current condition?:

Physician's examination ☐ x-ray ☐ other diagnostic test ☐

What relieves your pain?

What aggravates your pain?

Are you currently on any medication? If yes, what kind and what for?