# Health History Form

An accurate health history is important to ensure safe and effective treatment. If your health status changes in the future, please let me know. Note that all information provided will be considered confidential unless allowed or required by law. Your written permission will be required to release any information.

**Name:** ______________________________ **Date of Birth:** ___________ **Gender:** _____________

**Address:** ______________________________________________________________________________

**Occupation:** _______________________________ **Email:** ________________@______________

**Tel. (home):** _______________ **Tel. (work):** ______________ **Tel. (cell):** _____________________

**Have you received massage therapy before?** ☐yes ☐no

**May I follow up with you?** ☐yes ☐no
**If *yes*, indicate your preferred medium:** ☐cell ☐home ☐email ☐letter mail

**Who referred you?** _____________________________________________________________________

**Primary Care Physician's Name:** _________________________________ **Tel.:** _________________

**Primary Care Physician's Address:** ______________________________________________________

**Emergency Contact:** ______________ **Relationship:** _________________ **Tel.:** _________________

**General Health Status:** _________________________________________________________________

**What is your primary complaint?** _______________________________________________________

**Surgery:** ☐yes ☐no
*(If* yes, *please describe nature and date.)*

_____________________________________________

_____________________________________________

**Injury:** ☐yes ☐no
*(If* yes, *please describe nature and date.)*

_____________________________________________

**Present involvement with other healthcare?**
☐yes ☐no *(If* yes, *please describe.)*

_____________________________________________

_____________________________________________

**List all medications you are taking and their corresponding conditions.**
*(Including prescription drugs, vitamins/ minerals, herbal supplements, recreational drugs, birth control pill, etc.)*

________________________________

________________________________

**Do you have any internal pins, wires, artificial joints or special equipment?**
☐yes ☐no *(If* yes, *please describe.)*

________________________________

## Check all that apply

**Cardiovascular**

☐ high blood pressure
☐ low blood pressure
☐ chronic congestive heart failure
☐ heart attack / date: ________
☐ varicose / spider veins
☐ stroke / CVA / TIA
date: ________________
☐ pacemaker or similar device

Is there a family history of any of the above ☐yes ☐no

**Respiratory**

☐ chronic cough
☐ shortness of breath
☐ bronchitis
☐ asthma / wheezing
☐ emphysema
☐ pneumonia
☐ sinus problems

Is there a family history of any of the above ☐yes ☐no

**Infections**

☐ chickenpox
☐ hepatitis A, B, C
☐ tuberculosis
☐ HIV / AIDS
☐ herpes
☐ other ________________

**Skin / Hair**

☐ athlete's foot
☐ itching rashes
☐ eczema / psoriasis
☐ plantar warts
☐ sensitive skin / bruise easily
☐ dry skin / scalp
☐ sensitivity to oil or lotion
☐ other ________________

**Digestive Conditions**

☐ irritable bowel syndrome
☐ ulcers
☐ constipation
☐ Crohn's / colitis
☐ kidney / bladder
☐ liver / gallbladder

**Head / Neck**

☐ headaches
 ☐ tension
 ☐ migraine

frequency: ____________________

☐ eye glasses
☐ other vision problems?

please specify: ________________

☐ ear problems
☐ hearing loss / tinnitus
☐ TMJ
☐ vertigo
☐ dizziness
☐ head trauma
date: ________________

**Lifestyle**

☐ smoker
☐ high stress level
☐ regular exercise program

activities: ____________________

**Other Conditions**

☐ osteoporosis
☐ edema / swelling
☐ fibromyalgia
☐ chronic fatigue
☐ fainting

**Other Conditions (continued)**

☐ diabetes
 ☐ Type 1 (juvenile)
 ☐ Type 2 (adult onset)

year diagnosed________________

☐ cancer

location ____________________

☐ arthritis
 ☐ rheumatoid (autoimmune)
 ☐ osteoarthritis

location__ ________________

Is there a family history of arthritis?
☐yes ☐no

☐ epilepsy

Trigger(s)____________________

☐ loss of sensation

Where? ____________________
How often? __________________

☐ allergies / hypersensitivity

Trigger(s)____________________
Type of reaction ________________

☐ Medic-Alert bracelet

**Women's Health**

☐ pregnant? due: __________
☐ gynecological conditions
____________________

## Indicate current areas of pain and / or discomfort