Health History Form for Massage Therapy

Name: _______________________________ Date of Birth: __________________________________

Address: ____

City: __________________________________ Postal Code: ___________________________________

Home Phone: __________________________ Work Phone: ___________________________________

Cell Phone: ____________________________

Occupation: ___________________________ Email: ____

Family Physician: ______________________ Referring Physician: ______________________________

How did you hear about us? ____

What is the main reason for your visit today?

____

What was the cause of the injury?

____

What aggravates the condition? ____

What relieves the condition? ____

Has this condition occurred before and has it been resolved?

____

Are you currently under the care of any other practitioner for this condition?

____

Please list any medications that you are currently taking:

____

Please list any serious accidents, injuries or surgeries:

Do you participate in any activities, sports or hobbies?

____

Please CHECK any of the following conditions which apply and specify if they are past or present:

☐ Tension Headache ☐ High Blood Pressure ☐ Low Blood Pressure

☐ Migraine Headache ☐ Respiratory Condition ☐ Pregnancy

☐ Osteoporosis ☐ Rheumatoid Arthritis ☐ Osteoarthritis

☐ Skin Condition ☐ Cancer ☐ AIDS/HIV

☐ Hepatitis ☐ Digestive Conditions ☐ Seizure Disorder

☐ Fractures ☐ Sprains ☐ Swelling

☐ Insomnia ☐ Bruise Easily ☐ Depression/Anxiety

☐ Pins/Plates ☐ Cardiovascular Condition ☐ Kidney Condition

☐ Diabetes ☐ Other condition not listed

Please provide any additional information:

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CANCELLATION POLICY: **24 Hours' Notice** is required or a full appointment fee will be charged prior to the next appointment.

Fee Policy: I understand and agree that the cost of treatment is my responsibility, should private insurers or other providers fail to reimburse the clinic for services. All outstanding accounts over 30 days are overdue and will be charged interest at the rate of 2.5% per annum.

I hereby declare that the above information is accurate and complete to the best of my knowledge. I have disclosed all relevant past and present health information and agree to inform my therapist of any changes to the above information. I consent to Massage Therapy treatment.

Signature: ______________________________ Date: ______________________________