

Health History Form

Please note all information is kept confidential

Personal Information

Preferred Pronoun (he/him, she/her, they/them, etc): _____

Name: _____ Male/Female _____ D.O.B. _____

Complete Address: _____

Telephone #'s: HOME _____ WORK _____ CELL _____

Email address: _____

Occupation: _____

Physician's Name: _____ Telephone # _____

Office Location/Address: _____

Medications & Reason for usage: _____

Alternative therapies and last date seen: Chiropractor _____, Physiotherapy _____

Massage Therapy _____, Occupational Therapy _____, Other _____

Current Health Status

Primary Complaint: _____

Problem Areas:

Please indicate whether you experience Muscle Soreness (MS), Muscle Weakness (MW) or Pain (P)

___ Spine	___ Shoulder	___ Neck	___ Head
___ Elbow	___ Wrist	___ Hand	___ SI Joint
___ Hip	___ Knee	___ Ankle	___ Foot

Any other areas of discomfort: _____

Lifestyle: * Please indicate yes/no/sometimes *

Exercise: _____ Alcohol: _____ Drugs: _____ Smoke: _____ Caffeine: _____ Water: _____

Previous Injuries and Surgeries

*** Please list all injuries and surgeries in your lifetime***

Injury/Surgery	Date	Treatment Received
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___ Pacemaker ___ Cosmetic Implants ___ Pins/Plates/Needles (Location: _____)

Medical History (Please complete to the best of your knowledge)

- Cardiovascular: Hemophilia Buerger's disease
 Stroke Raynaud's disease
 Dizziness Myocardial infarction
 Chest Pain High blood pressure
 Low blood pressure Varicose veins
 Congestive heart failure Deep vein thrombosis
- Respiratory: Emphysema Bronchitis (Acute/Chronic)
 Asthma Chronic Cough
 Cystic Fibrosis Breathing difficulty
- Neurological: Epilepsy Carpal Tunnel Syndrome
 Multiple Sclerosis Thoracic Outlet Syndrome
 Parkinson's Bell's Palsy
 Cerebral Palsy Neuritis/Neuralgia/Causalgia
 Sciatica Other: _____
- Muscles/Joints: Osteoarthritis Rheumatoid arthritis
 Ankylosing Spondylitis Osteoporosis
 Other (please specify) _____
- Allergies: General allergies *please specify* _____
 Anaphylactic shock
- Gastrointestinal: Crohn's disease prolonged constipation
 Ulcerative colitis prolonged diarrhea
 chronic abdominal discomfort pelvic inflammatory disease
- Other: Diabetes Hearing/vision loss
 Cancer skin irritation (eczema/psoriasis)
 Hepatitis Fibromyalgia
 HIV/AIDS Tuberculosis
 Pregnancy Miscarriages

pillars
OF HEALTH

Consent to treatment and Cancellation Policies

I, _____, acknowledge that there are possible risk factors and side effects of a massage therapy treatment. Any questions I may have regarding these side effects or risk factors can be discussed openly with the therapist. This consent may be revoked at any time. I have provided the therapist with up to date and accurate medical information and understand that all medical information provided is confidential and may not be released to another health care professional or health insurance company without prior consent.

Registered Massage Therapists are unable to diagnose a complaint/problem. Through testing, a proposed treatment plan is discussed and noted. It is your responsibility as a client to provide appropriate and helpful feedback to the therapist. The client has the right to stop or change the treatment at anytime.

In the interest of mutual respect for each others time, and for other patients of our clinic we have a cancellation policy in place. Cancellations made with less than 24 hours notice will be charged a fee of half the treatment value. I, _____ understand that I have been informed of this cancellation policy.

Having reached the age of majority and being legally competent, I provide my full, voluntary informed consent to treatment.

Signature: _____ Date: _____

To be completed by parent/guardian if client is under 18 years of age:

I, _____ as legal guardian or acting power of attorney of _____ give consent to treatment.

I _____ give consent for _____ to share such healthcare information with the massage therapist as it may be beneficial for the care of the above-mentioned client.

Parent/Guardian Signature: _____ Date: _____