

Body Kneads Massage Centre Health History Form

The information request below will assist us in treating you safely. Please note that all the information provided below will be kept confidentially unless allowed or required by law. Your written permission will be required to release any information.

Name: (please print) _____
(first & last)

Date of Birth: _____
(mm/dd/yr)

Occupation: _____

Have you received massage therapy before? Yes No

Did a health care practitioner refer you for massage therapy? Yes No If yes, who _____
If no, please indicate how you heard about the clinic. yellow pages flyer friend/family/coworker
 radio other: _____

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

Soft tissue/joint discomfort

- neck low back
- mid back upper back
- arms L/R legs L/R
- knees L/R shoulders L/R
- Other _____

Infections

- hepatitis
- skin conditions
- TB
- HIV
- herpes

Other Conditions

- loss of sensation, where? _____
- diabetes, onset: _____
- allergies/hypersensitivity to what? _____

type of reaction : _____

- epilepsy
- cancer, where? _____

- skin conditions, what? _____

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, what? _____

Overall, how is your general health? _____

Primary Care Physician: _____

Other Health Care:

- chiropractic naturopath
- physiotherapy osteopathy
- acupuncture reflexology
- other _____

What is your primary complaint: _____

Current Medications: _____

Condition it treats: _____

Surgery – date _____
nature: _____

Surgery – date _____
nature: _____

NOTES (for therapist use)

Injury – date _____
nature: _____

Injury – date _____
nature: _____

Do you have any other medical conditions? (eg. Digestive conditions, hemophilia, osteoporosis, mental illness)
 Yes No Explain _____

Do you have any internal pins, wire, artificial joints or special equipment? Yes No
what? _____ where? _____

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Date of initial health history _____
Update 1 _____ Update 2 _____
Update 3 _____ Update 4 _____