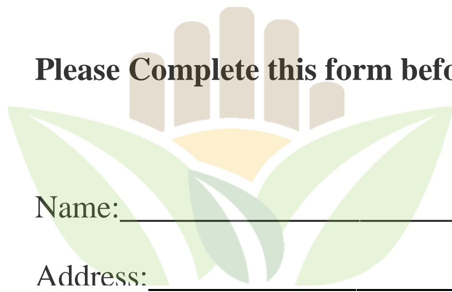
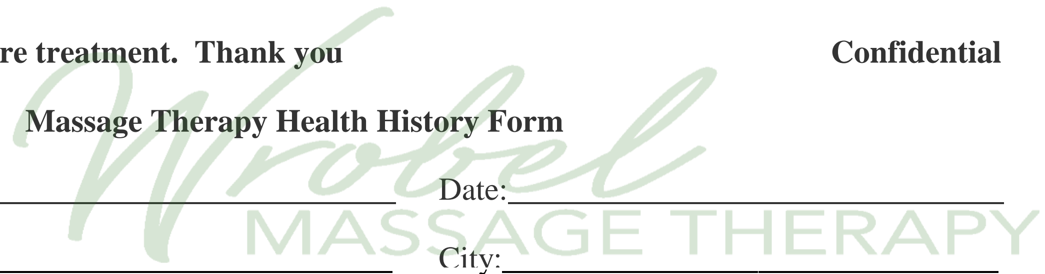




Please Complete this form before treatment. Thank you **Confidential**

Massage Therapy Health History Form

Name:_______________________________________ Date:__________________________

Address:_____________________________________ City:_________________________

Postal Code:______________ Home Telephone:_______________ Cell:____________________

Date of Birth:________________________ Occupation:_________________________________

Email Address:____

Family Physician and location:____

Where did you first hear about us?____

What brings you for a massage? Relaxation_____ Stress______ Injury _____ Pain_______

Medical Background:

Circulation:

__High Blood Pressure
__Low Blood Pressure
__Heart Condition
__Diabetes
__Varicose Veins
__Poor Circulation
__Dizziness
__Phlebitis
__Smoking
__Cancer
__Stroke
__Migraines

Muscles and Joints

__Arthritis
__Bursitis
__Fractures
__Whiplash
__Neck Pain
__Shoulder Pain
__Low Back Pain
__Stiff Joints
__Swollen Joints
__Poor Posture
__Foot Problems
__TMJ
__Fibromyalgia

General

__Right Handed
__Left Handed
__#of Children
__Vision Problems
__Hearing Problems
__Asthma

Digestion/Elimination

__Constipation
__Diarrhea
__Liver/Gallbladder
__Kidney/Bladder
__Ulcers
__ Nausea

Nervous System:

__Nervousness
__Depression
__Fatigue
__Insomnia
__Sciatica

Immune:

__Allergies

Please list Allergies Below

____

__Aids

__Contagious Skin Condition

Women:

__PMS

__Pregnant

__Menopause

Continued on the next page:

Please list any other form of treatment you are receiving. Eg. Chiropractic: ____________________

____

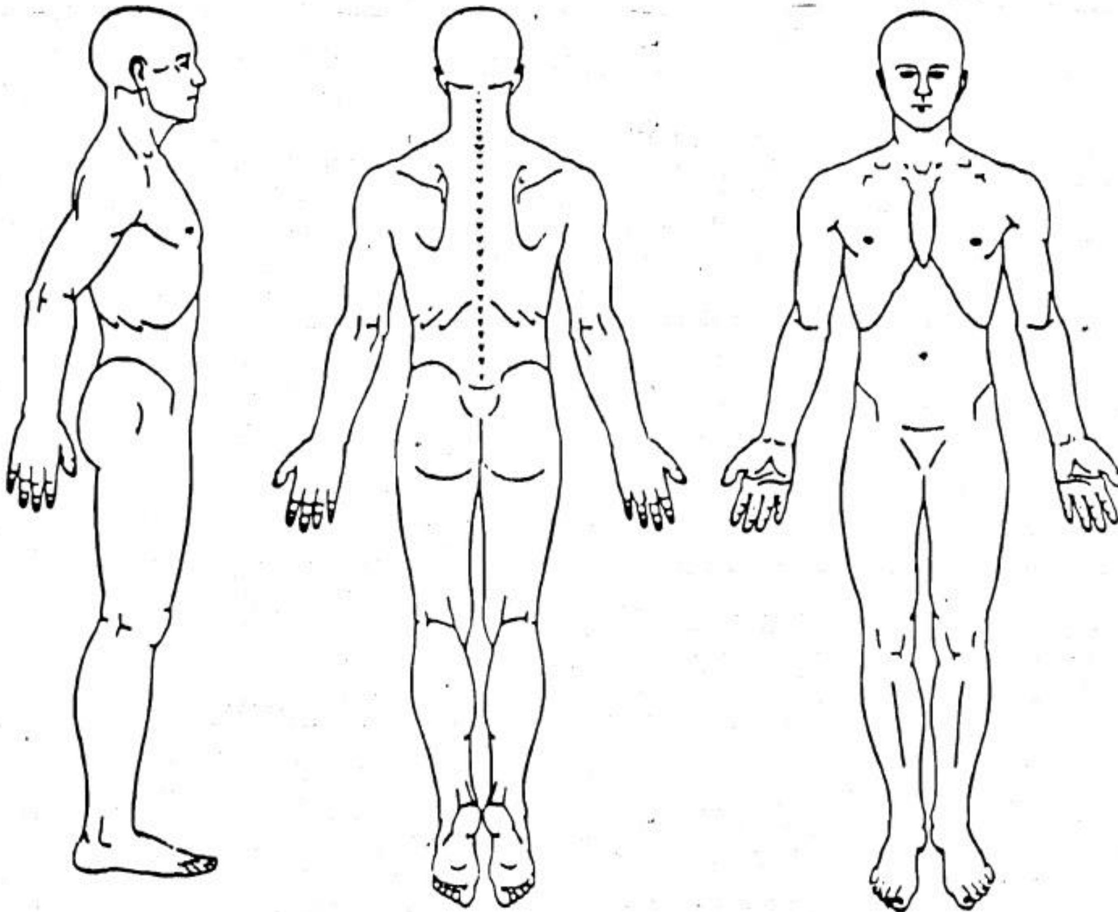
Please list any past surgery and date: ____

____

Please list any medication you are currently taking:____

____

Please indicate on the diagram where you are feeling any pain or discomfort.



Consent to Treatment

I hereby consent to massage therapy treatments as described by my therapist. I understand and agree to all the techniques that will be used, their desired effects, possible side effects and anticipated duration of treatment. I recognize that my therapist and I are partners in my health care program and I agree to take responsibility for my health care choices.

Signature:____ Date:______________________________