Confidential Patient Health Record

Date: _____

An accurate health history is important to ensure that it is safe for you to receive massage therapy.
All information is strictly confidential and will only be released with your written consent.

Please print clearly

Client Information

Name:		Address:	
City:	Province:		
Home Phone:	Birthdate (dd/mm/yy): / /		Sex:
May we contact you by email? □ Yes □ No		Email Address:	
Occupation:		Work Phone:	
Name of Primary Care Physician:		Address & Phone:	

Have you received massage therapy before? ___ Yes ___ No

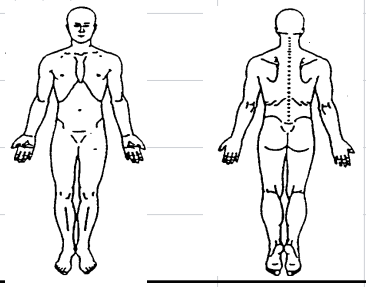
Did a health care practitioner refer you for massage therapy? ___ Yes ___ No

General Health Status

Are you currently seeing a health practitioner? □ Yes □ No

If yes, please specify (i.e. chiropractor, physiotherapist, psychologist, etc.):

What is your major complaint (i.e. areas of focus for the massage)?



Overall, how is your health (i.e. poor, fair, good, excellent)?

Please list all current medications and/or tests (i.e. MRI, ultrasound, cat scan, etc.) and the condition:

Medication	Condition

Other medical conditions (digestive conditions, hemophilia, osteoporosis, mental health issues): ___ Yes ___ No

If yes, specify: _____

Presence of internal pins, wires, artificial joints or other? ___ Yes ___ No If yes, specify:

Please list all previous injuries/surgeries and the date they occurred:

Injury/Surgery	Date

Health History

Please check any that apply

Muscle & Joint Pain:
Indicate L = left, R = right
- □ Neck _____
- □ Back _____
- □ Jaw _____
- □ Shoulder _____
- □ Arm _____
- □ Hand _____
- □ Hip _____
- □ Upper Leg _____
- □ Knee _____
- □ Lower Leg _____
- □ Ankle _____
- □ Foot _____

Head and Neck:
- □ History of Headaches
- □ History of Migraines
- □ Vision Problems
- □ Vision Loss
- □ Ear Problems
- □ Hearing Loss

Women
- □ Pregnant due: _____
- □ Gynecological Conditions: _____

Respiratory:
- □ Chronic cough
- □ Bronchitis
- □ Asthma
- □ Emphysema
- □ Shortness of Breath
- □ Smoker
- □ Other _____

Skin:
- □ Sensitive
- □ Rashes
- □ Cold Sores
- □ Warts
- □ Bruise Easily
- □ Skin Conditions

Arthritis:
Location: _____
Type: _____
Family History:
___ Yes ___ No

Cardiovascular:
- □ High blood pressure
- □ Low blood pressure
- □ Chronic Congestive Heart Failure
- □ Heart disease
- □ Heart attack
- □ Phlebitis
- □ Stroke/CVA
- □ Pacemaker / Other
- □ Varicose veins
- □ Other: _____

Digestive:
- □ Constipation
- □ Liver/gallbladder
- □ Kidney/bladder
- □ Diabetes
- □ Hernia
- □ Ulcer
- □ Colitis
- □ Other _____

Infections:
- □ Hepatitis
- □ TB
- □ HIV/AIDS
- □ Herpes
- □ Infectious Skin Diseases

Other Conditions
- □ Loss of Sensation
- □ Diabetes Onset: _____
- □ Allergies/hypersensitivity (i.e.Anaphylaxis or skin irritation) _____
- □ Epilepsy
- □ Cancer
- □ Mental Health Issues: _____
- □ _____

Lifestyle Stress Level:
- □ High
- □ Moderate
- □ Very Little

Have you ever suffered a traumatic event? ___Yes ___No
If Yes, please indicate___chilhood ___adulthood ___recently
Is there anything you would like me to know about it? _____

Please read carefully:

I have stated all of my medical conditions and will inform my massage therapist of any changes in my health status in the future.

I agree to give 24 hours notice for the cancellation of an appointment; otherwise, the full treatment will be charged.

I understand that I may stop or alter the treatment at any time during the massage. I give my consent for the massage therapy treatment.

_____ _____
Client Name (please print) Date:

_____
Client Signature

Updated: Date: _____ Signature: _____