Massage Therapy Patient History Form

Name:

Recent Healthcare:

In the past 3 months have you had or visited any of the following:

Family Dr. _____ Chiropractor _____ Physiotherapy _____
Massage _____ Naturopathy/Homeopathy _____

Medical History

Please indicate if you have or have had any of the following conditions:

High Cholesterol _____
Nervous system disorders _____
Headaches _____
Jaw Pain (TMJ) _____
Cancer _____
Blood Disorders _____
Allergies _____
Osteoporosis _____
Arthritis _____
Chronic Fatigue Syndrome _____
Fibromyalgia/Polymyalgia _____
Other (Please Specify) _____

Recent Surgery _____
Whiplash _____
Fainting/Dizziness _____
Lung Condition _____
Skin Conditions/Irritations _____
Diabetes _____
Epilepsy _____
Unexplained Weight Loss _____
Pregnancy _____

Do you have any of the following low back conditions?

Herniated/bulging Disc _____ Ankylosing Spondylitis _____ Laminectomy _____
Spinal Stenosis _____ Spondylolysthesis _____ Spinal fusion _____
Disc disease _____ Pinched Nerve _____ Other _____

Have you had or have any of the following heart/blood vessel conditions?

Bleeding Disorder _____
High Blood Pressure _____
Low Blood Pressure _____
Heart Attack _____
Heart Disease _____
Angina _____

Stroke_____
Pacemaker _____
Varicose Veins _____
Phlebitis _____
Poor Circulation _____

Other (Please Specify) _____

OVER ⇨

Massage Therapy Patient History Form page 2

Please list any prescribed medications or over the counter medications you take including painkillers and anti-inflammatories (such as Tylenol and Ibuprofen) and for what condition:

_____

Present areas of complaint: (please list the most severe one first, if multiple areas)

1._____

2._____

If pain is present:

When does it occur? _____

Does anything relieve the pain? _____

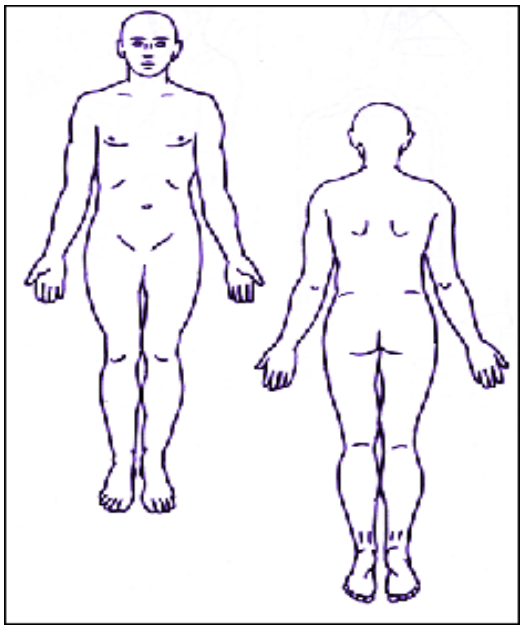
What aggravates it? _____

Have you been involved in a motor vehicle accident? Yes ___ No____ Date_____

Details: front, side or rear impact?, head rest up?, air bag deployed?

_____

Please indicate areas of pain below: Mark: **X** for pain, **O** for stiffness and **N** for numbness:



The information I have provided is accurate to the best of my knowledge. All information contained within this document is strictly confidential and will be shared only with those permitted by the patient.

Signature _____ Date: _____