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Health History

For Your Information:

An accurate health history is important to ensure that it is safe for you to receive massage treatment. If your health status changes in the future, please let me know.

Name:				Date:	
Address:				Tel:(Res)	
City:	Prov	PC:		(Bus)	
Date of Birth:				(Cell)	
Occupation:				Email:	
Where Did You Hear About Us?				Address:	
Emergency Contact:				Tel:	

What is your primary complaint

Please indicate conditions you are experiencing, or have experienced in the past

Respiratory

- chronic cough
- shortness of breath
- bronchitis / pneumonia
- asthma
- emphysema

Head / Neck

- vision problems
- vision loss
- ear problems
- hearing loss
- headaches / migraines

Soft Tissue / Joint Discomfort and its nature

- neck _____
- low back _____
- mid back _____
- upper back _____
- shoulders _____
- arms _____
- hands _____
- legs _____
- knees _____
- feet/ankles _____
- hips _____
- spinal abnormalities _____

Cardiovascular

- high blood pressure
- low blood pressure
- chronic congestive heart failure / heart disease
- phlebitis
- stroke / CVA
- pace maker or similar

Skin

- psoriasis
- eczema
- non infectious skin condition
- infectious skin condition

Please Draw Your Pain

xxx Burning == Numbness \$\$\$ Aching
 !!!!! Stabbing *** Cramping ### Other

Other Conditions

- loss of sensation
- diabetes (onset _____)
Type _____
- allergies (i.e:anaphylaxis or skin irritation/hives)
- epilepsy
- cancer
- arthritis(incl. family hx)
- osteoporosis/osteopenia
- dizziness

Infections

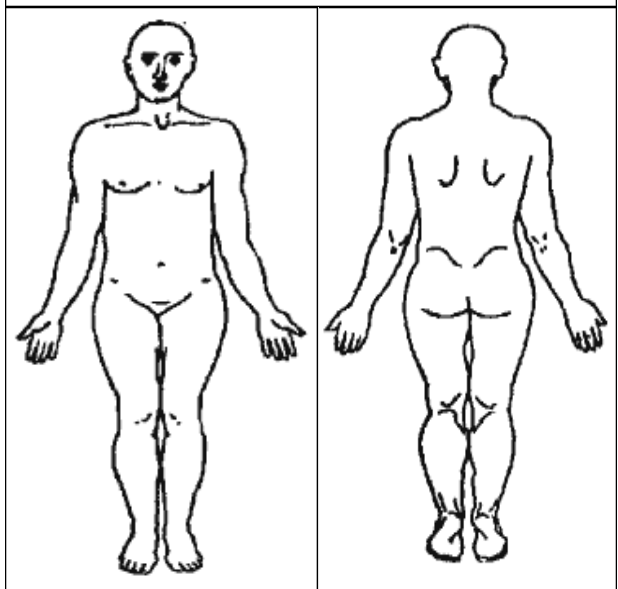
- hepatitis (Type_____)
- TB (tuberculosis)
- HIV

Women

- Pregnant (Due:_____)
- Other _____

Other Health Condition

- _____



Continued on reverse