Lisa SMITH RMT
Registered Massage Therapist
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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

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

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

Head / Neck
- ☐ vision problems
- ☐ vision loss
- ☐ ear problems
- ☐ hearing loss
- ☐ headaches / migraines

Skin
- ☐ psoriasis
- ☐ eczema
- ☐ non infectious skin condition
- ☐ infectious skin condition

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

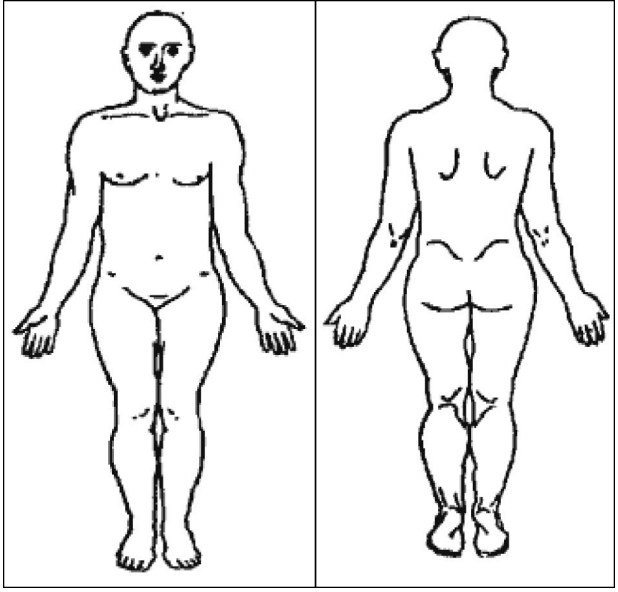
Women
- ☐ Pregnant (Due:_____)
- ☐ Other _____

Other Health Condition
- ☐ _____

Soft Tissue / Joint Discomfort and its nature
- ☐ neck _____ ☐ hands_____
- ☐ low back _____ ☐ legs _____
- ☐ mid back_____ ☐ knees_____
- ☐ upper back_____ ☐ feet/ankles_____
- ☐ shoulders_____ ☐ hips_____
- ☐ arms _____ ☐ spinal abnormalities _____

Please Draw Your Pain

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



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