MASSAGE THERAPY
HEALTH HISTORY FORM

Uxbridge Massage Therapy
82 Bolton Drive
Uxbridge, L9P1W9 647-226-2641

Personal Information

Name:_____ Date:_____

Address:_____ City and Postal Code:_____ Phone (home):_____

Date of Birth:_____Occupation:_____ Phone (work):_____

E-mail Address:_____ Height:_____ Weight:_____

Sports and Hobbies:_____ What is your general health status?_____

Medical Doctor Name and Address:_____

Current involvement with other health practitioners:_____

Have you had massage before?____ What is the reason for your massage therapy visit?_____

Do you have insurance coverage for Massage Therapy? _____

Health History

(Please check off the conditions that you are currently experiencing or have experienced often in the past)

HEAD/NECK
- ☐ Headaches (type:_____) Migraines
- ☐ Vision problems
- ☐ Hearing loss
- ☐ Earaches
- ☐ Other:_____

RESPIRATORY
- ☐ Chronic cough
- ☐ Pneumonia
- ☐ Shortness of breath
- ☐ Smoking
- ☐ Breathing disorders (type:_____)
- ☐ Other:_____
- ☐ Family history of these disorders

SKIN
- ☐ Skin conditions(type:_____)
- ☐ Bruise easily
- ☐ Plantar warts
- ☐ Other:_____

INFECTIONS
- ☐ Hepatitis
- ☐ Tuberculosis
- ☐ HIV, AIDs
- ☐ Other:_____

WOMEN
- ☐ Menstrual problems
- ☐ Gynecological conditions
- ☐ Gynecological surgery
- ☐ Pregnant (due:_____)
- ☐ Children (#:_____)
- ☐ Menopausal problems
- ☐ Other:_____

CARDIOVASCULAR
- ☐ High blood pressure
- ☐ Low blood pressure
- ☐ Poor circulation
- ☐ Heart disease/heart attack
- ☐ Pacemaker
- ☐ Chronic heart failure
- ☐ Stroke
- ☐ Varicose veins
- ☐ Other:_____
- ☐ Family history of these disorders

OTHER CONDITIONS
- ☐ Difficult digestion
- ☐ Constipation
- ☐ Crohn's disease or colitis
- ☐ Ulcers
- ☐ Diabetes
- ☐ Gall bladder
- ☐ Liver
- ☐ Allergies _____
- ☐ Cancer (type:_____)
- ☐ Epilepsy
- ☐ Multiple sclerosis
- ☐ Parkinson's disease
- ☐ Osteoporosis
- ☐ Fibromyalgia
- ☐ Chronic fatigue syndrome
- ☐ Artificial joints, limbs wires, internal pins or special equipment
- ☐ Use wheelchair/walker
- ☐ Thyroid
- ☐ Loss of sensation(where:____)
- ☐ Other_____

MUSCULOSKELETAL
- ☐ Joint sprain:_____
- ☐ Muscle strain:_____
- ☐ Fracture:_____
- ☐ Dislocation_____
- ☐ Whiplash
- ☐ Low back pain
- ☐ Arthritis:_____
- ☐ Carpal tunnel syndrome
- ☐ Family history of arthritis
- ☐ Other_____

Injury and Surgery

(Please list off any injuries or surgeries that you have had in the past which may affect any massage therapy treatment)

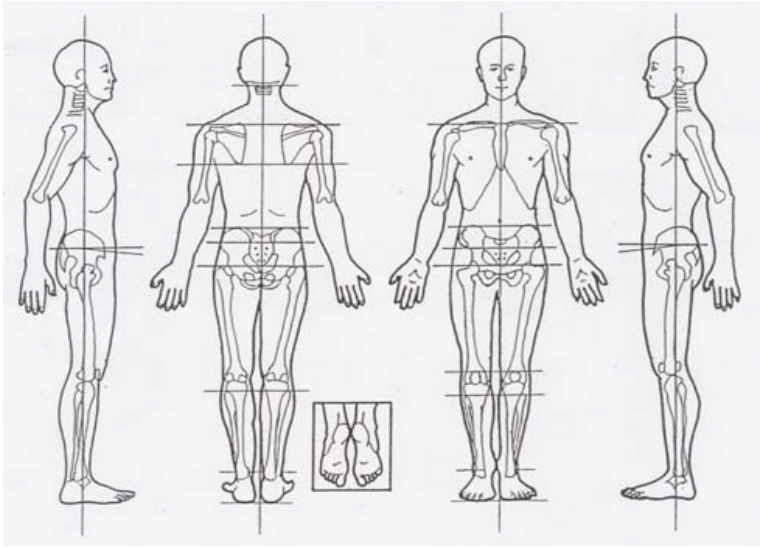
Type: _____	**Type:** _____	**Type:** _____
Date: _____	**Date:** _____	**Date:** _____
Current symptoms: _____	**Current symptoms:** _____	**Current symptoms:** _____
_____	_____	_____
_____	_____	_____

PAIN AND STIFFNESS

(Please check off any areas of the body where you are experiencing any pain or stiffness)

- ☐ jaw neck
- ☐ shoulders
- ☐ upper back
- ☐ mid back
- ☐ lower back
- ☐ elbow (left or right)
- ☐ wrist (left or right)
- ☐ hip (left or right)
- ☐ thigh (left or right)
- ☐ knee (left or right)
- ☐ leg (left or right)
- ☐ ankle (left or right)
- ☐ other: _____

_____



MEDICATIONS AND OTHER INFORMATION

(Please list any other personal or health information which you feel is applicable to your massage therapy needs or treatments)

_____

_____

_____

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I understand that the information that I give on this Health History Form will be confidential and will be used for no other purpose other than the registered massage therapist's records. The Massage Therapy Act, 1991 requires that every client's health record be maintained for at least ten (10) years from the date of their last visit. You may access copies of your client health record at any time by contacting your massage therapist.

Signature:_____ Date:_____