



THERAPEUTIC MASSAGE HEALTH HISTORY FORM

All information disclosed is confidential except when required by law or your verbal & written consent is given. If there are any changes, please update with the therapist so they can help treat you safely.

PERSONAL INFORMATION

NAME: _____ D.O.B _____ OCCUPATION: _____

ADDRESS: _____ CITY: _____ POSTAL CODE: _____

TEL: (H) _____ (W) _____ (Cell): _____ E-MAIL: _____

PRIMARY COMPLAINT: _____ TODAYS DATE: _____

HOW IS YOUR GENERAL HEALTH STATUS: _____

HOW DID YOU HEAR ABOUT US? _____

HAVE YOU HAD SWEDISH MASSAGE THERAPY BEFORE? Y / N

HAVE YOU HAD HOT STONE MASSAGE THERAPY BEFORE? Y / N

MEDICAL INFORMATION

Please indicate conditions you're presently experiencing or have experienced in the past & state the date of onset.

RESPIRATORY CONDITIONS: Y / N

Chronic cough ___ DATE: _____
 Shortness of breath ___ DATE: _____
 Bronchitis ___ DATE: _____
 Asthma ___ DATE: _____
 Emphysema ___ DATE: _____

INFECTIONS: Y / N

Skin Conditions ___ DATE: _____
 Hepatitis ___ DATE: _____
 TB ___ DATE: _____
 HIV ___ DATE: _____

ALLERGIES: Y / N

Cosmetic Allergy/Perfume ___ DATE: _____
 Natural Plant Minerals ___ DATE: _____
 Essential Oils or Synthetics ___ DATE: _____
 Other: _____ DATE: _____

CARDIOVASCULAR CONDITIONS: Y / N

High Blood Pressure ___ DATE: _____
 Low Blood Pressure ___ DATE: _____
 Heart Failure (CCHF) ___ DATE: _____
 Heart Attack ___ DATE: _____
 Stroke/CVA ___ DATE: _____
 Pacemaker or similar device ___ DATE: _____
 Heart Disease ___ DATE: _____
 Phlebitis / Varicose Veins ___ DATE: _____

SKIN CONDITIONS? Y / N

Acne ___ DATE: _____
 Dermatitis ___ DATE: _____
 Skin Cancers ___ DATE: _____
 Skin Lesions ___ DATE: _____
 Eczema ___ DATE: _____
 Psoriasis ___ DATE: _____
 Rosacea ___ DATE: _____
 Other: _____ DATE: _____

FOOT CONDITIONS: Y / N

DATE: _____
 Please Specify: _____

WOMEN: Pregnant ___ DUE: _____ Other: _____

OTHER MEDICAL / GYNEACOLOGICAL CONDITIONS: Y / N: Onset: _____

Please Specify: _____

OTHER CONDITIONS: Y / N

Cancer ___ DATE: _____
 Diabetes & Type: ___ DATE: _____
 Arthritis ___ DATE: _____
 Epilepsy ___ DATE: _____
 Loss of Sensation ___ DATE: _____
 Hearing Problems ___ DATE: _____
 Vision Problems ___ DATE: _____
 Osteoporosis ___ DATE: _____

SKIN TYPE: Dry ___ Combination ___ Normal ___ Dehydrated ___ Oily ___ Mature: ___ Porous ___

FAMILY HISTORY OF ANY CONDITIONS?: Y / N: *Please Specify:* _____

ANY PRESENCE OF INTERNAL PINS, WIRES, ARTIFICIAL JOINTS, SPECIAL EQUIPMENT? Y / N

Please Specify(what & where): _____ DATE: _____

ANY INJURIES: (NATURE) _____ DATE: _____

ANY SURGERIES: (NATURE) _____ DATE: _____

CURRENT MEDICATIONS: _____ DATE: _____

- CONDITION(S) IT TREATS: _____

PRIMARY MEDICAL DOCTOR: _____ TEL: _____

ADDRESS: _____

- *IS THIS THE PHYSICIAN THAT REFERRED YOU TO US OR FOR MASSAGE THERAPY?* Y / N

ARE YOU CURRENTLY BEING TREATED BY ANOTHER HEALTH CARE PROFESSIONAL? Y / N *IF YES:*

TYPE OF TREATMENT: _____ CONDITION BEING TREATED: _____

SINCE WHEN? (DATE): _____ FEEDBACK: _____

- *IS THIS THE FACILITY THAT REFERRED YOU TO US OR FOR MASSAGE THERAPY?:* Y / N

IS THERE ANYTHING ELSE YOU WOULD LIKE TO TELL US? Y / N

I HEREBY CERTIFY THAT THE INFORMATION PROVIDED ON THIS FORM IS ACCURATE TO THE BEST OF MY KNOWLEDGE AND UNDERSTAND THAT IT IS MY RESPONSIBILITY TO INFORM MY REGISTERED MASSAGE THERAPIST OF ANY CHANGES IN MY HEALTH. I AGREE TO ALLOW THE PHYSICIANS WORKING WITHIN NATURA WELLNESS CLINIC TO EVALUATE MY FILES FOR FURTHER ASSESSMENT (IF NEEDED) TO HELP TREAT ME SAFELY.

CLIENT NAME: _____ **DATE:** _____

CLIENT'S SIGNATURE: _____

SECONDARY DECISION MAKER'S NAME: _____ **DATE:** _____

RELATIONSHIP TO CLIENT: _____ **SDM SIGNATURE:** _____

ADDITIONAL NOTES FOR UPDATE:

DATE: _____ CLIENT SIG.: _____

DATE: _____ CLIENT SIG.: _____

DATE: _____ CLIENT SIG.: _____

YEARLY UPDATE:

PRIMARY COMPLAINT: _____ CLIENT'S SIGNATURE: _____ DATE: _____

PRIMARY COMPLAINT: _____ CLIENT'S SIGNATURE: _____ DATE: _____

PRIMARY COMPLAINT: _____ CLIENT'S SIGNATURE: _____ DATE: _____