Myokinematic massage therapy

# CONFIDENTIAL HEALTH HISTORY FORM

Name:_____

Address: _____

_____ Postal Code: _____

Phone: Home (_____)_____

Work (_____)_____

Cell (_____)_____

Gender: ___M ___F ___X Date of Birth: _____ Occupation:_____

Day / Month / Year

E-mail: _____

Emergency Contact Name: _____ Phone: (____) _____

Physician Name: _____ Phone: (____) _____

How did you hear about our clinic?_____

**The following information will be used to help plan safe and effective massage sessions.**
**Please answer the questions to the best of your knowledge.**

Have you received massage therapy before: ☐ YES ☐ NO

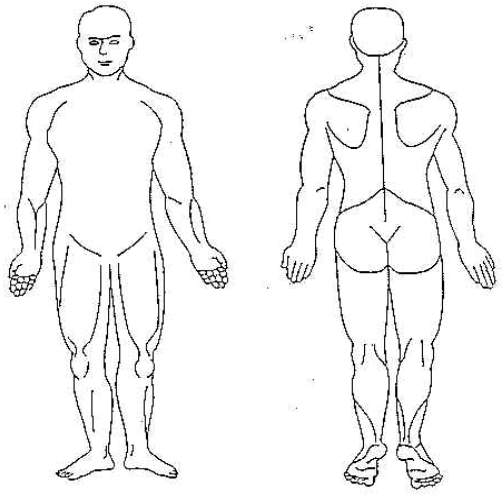
Primary reason you are seeking massage therapy:

_____

When did you first notice this issue?

_____

Please indicate on this diagram where pain or discomfort is occurring:



Any additional comments:_____

_____

_____

Please indicate conditions you are currently experiencing (C) or have experienced in the past (P):

| | | | | | | | |
|---|---|---|---|---|---|---|---|
| ☐ | High Blood Pressure | ☐ | Asthma | ☐ | Arthritis | ☐ | Muscle/Joint Issues: |
| ☐ | Low Blood Pressure | ☐ | Shortness of Breath | ☐ | Osteoporosis | ☐ | Neck |
| ☐ | Heart Attack | ☐ | Emphysema | ☐ | Bursitis | ☐ | Back |
| ☐ | Heart Disease | ☐ | Bronchitis | ☐ | Sprain | ☐ | Shoulder |
| ☐ | Stroke/CVA | ☐ | Epilepsy/ Seizures | ☐ | Strain | ☐ | Elbow/Wrist/Hand |
| ☐ | Congestive Heart Failure | ☐ | HIV/ AIDS | ☐ | Fracture | ☐ | Hip |
| ☐ | Anemia | ☐ | Cancer | ☐ | Numbness/ Tingling | ☐ | Knee |
| ☐ | Hemophilia | ☐ | Tumors | ☐ | Dizziness/ Vertigo | ☐ | Ankle/Foot |
| ☐ | Phlebitis/ Varicose Veins | ☐ | Edema/ Inflammation | ☐ | Headaches/ Migraines | | |
| ☐ | Diabetes | ☐ | Allergies/ Sensitivities | ☐ | Insomnia/ Sleep Difficulties | | |
| ☐ | Digestive Conditions | ☐ | Skin Conditions | ☐ | Anxiety | | Women only: |
| ☐ | Vision or Hearing Loss | ☐ | Poor Circulation | ☐ | Excessive Stress | | Pregnancy ☐ |
| ☐ | Pins/Screws/Artificial Joints | ☐ | Artherosclerosis | | | | |

List any other medical conditions not listed:

_____

_____

Are you presently taking any medications (prescribed or over the counter)? ☐ YES ☐ NO
*If yes, please list medication(s) and the condition for which it is being used.*

_____

_____

Are you seeing any other health care professionals or receiving any other medical treatment?_____

_____

Briefly list any surgeries or injuries you have experienced including the date:

_____

_____

What type of physical activity, exercise, stretching do you do? _____

_____

How many times per week? _____

Is there anything else about your health history that would be important for the massage therapist to know?

_____

_____

I, _____(print name) understand that the massage I receive is provided for therapeutic purposes. If I experience any pain or discomfort during this session, I will immediately inform the therapist so that the pressure and/or technique may be adjusted to my level of comfort. I further understand that massage should not be construed as a substitute for medical examination, diagnosis, or treatment and that I should see a physician for any mental or physical ailment that I am aware of. I understand that massage therapists are not qualified to perform spinal or skeletal adjustments, or prescribe and that nothing said in the course of the session given should be construed as such. Due to the fact that massage should not be performed under certain medical conditions, I affirm that I have stated all my known medical conditions, and answered all questions honestly. It is my responsibility to keep the therapist updated as to any changes in my medical profile and understand that there shall be no liability on the therapist's part should I fail to do so.

I understand that payment is expected at the time of the appointment unless previous arrangements have been made, and that if I fail to cancel an appointment 24 hours in advance, I will be charged for the missed appointment.

Signature:_____ Date:_____

Updated:_____

Updated:_____