All client information is confidential, and written authorization will be obtained prior to the release of any information. An accurate health history is important to ensure that it is safe for you to receive a massage treatment. You have the right to give, withhold, or withdraw consent to the collection, use, or disclosure of your personal health information. If your health status changes in the future, please let your massage therapy student know.

Health History Information

Name: ____ Date: ______________________________________

Address: ____ Postal Code: _____________ Cell Phone: __________________________

Work Phone: _______________________ Email ________________________________ Birth date: ___________________________

Age: ______ Referred by: __________________________________ Language preferences: ___________________________________

Occupation/Area of Study: ____

Family Physician: ______________________________ Physician Phone Number: ____

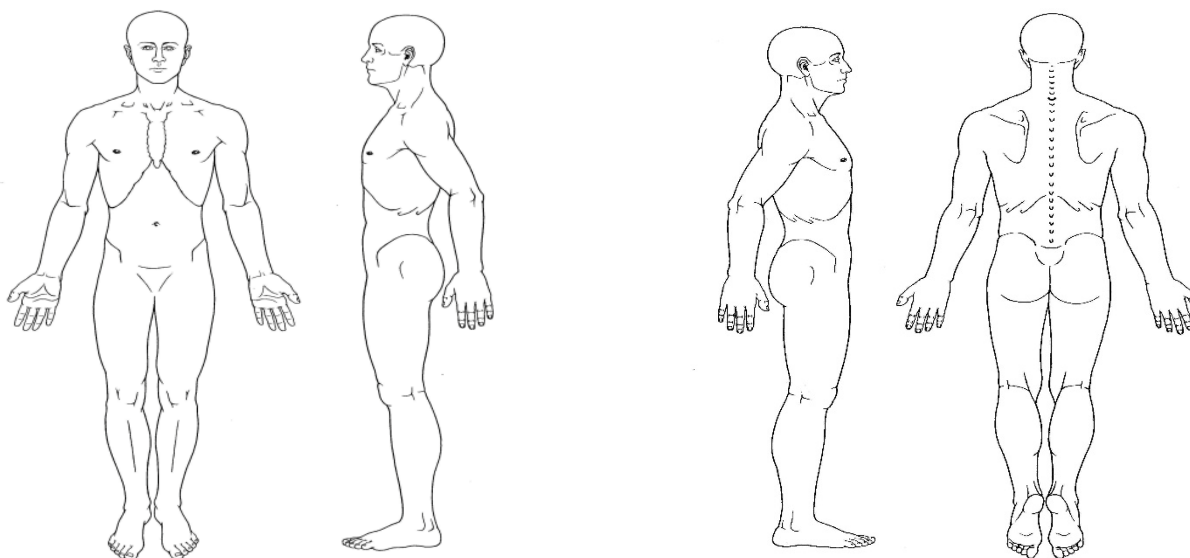
Emergency Contact's Name: ____________________________________ Emergency Contact's Phone: ___________________________

Reason for seeking Massage Therapy: ____

History of massage care: ____

Mobility/accessibility needs: ____

Please locate areas of pain and/or discomfort on the chart below:



Head / Neck

- ☐Vision Impairment
- ☐Migraines
- ☐Vertigo/Dizziness
- ☐Hearing Impairment

Cardiovascular System

- ☐High Blood Pressure: _____/_____
- ☐Low Blood Pressure: _____/_____
- ☐Pacemaker
- ☐Heart Disease / Condition
- ☐Varicose Veins
- ☐Phlebitis
- ☐Stroke / CVA
- ☐Edema
- ☐Chronic Congestive Heart Failure
- ☐Poor Circulation

Nervous System

- ☐Sensory Loss
- ☐Numbness/Tingling
- ☐Sciatica
- ☐MS
- ☐Parkinsons
- ☐Seizures
- ☐Paralysis
- ☐Sensitivity to pressure
- ☐Sensitivity to pain

Respiratory System

- ☐Asthma
- ☐Bronchitis
- ☐Breathing Difficulties
- ☐Emphysema
- ☐Chronic Cough

Immune System

- ☐Allergies – Type: _____________
- ☐Sinusitis

Motor Vehicle Incident: Y N

Date of MVI:

____

Musculoskeletal:

- ☐Arthritis OA or RA
- ☐Bursitis
- ☐Tendonitis
- ☐Whiplash
- ☐Tension Headaches
- ☐Fractures
- ☐Dislocations
- ☐T.M.J.D.
- ☐Carpal Tunnel R / L
- ☐Muscular Pain
- ☐Muscular Weakness
- ☐Muscle Joint Stiffness
- ☐Swollen Joints
- ☐Hypermobility
- ☐Plates, Pins, Screws
- ☐Fibromyalgia

Skin

- ☐Rashes/Eruptions
- ☐Sensitive
- ☐Bruise Easy
- ☐Eczema

Surgery (type/date):

____

____

____

____

Please update any changes to your PHI since your last appointment:

____

____

____

____

____

____

☐ Please check this box if you choose not to disclose any further personal health information at this time.

Other

- ☐Anxiety
- ☐ Depression
- ☐ Mental Health – Type:_______________
- ☐ Fatigue
- ☐ Cancer
- ☐ Insomnia

Endocrine

- ☐Diabetes

Reproductive

- ☐Menopause
- ☐Pregnant # of weeks_______

Any other conditions (Immune dysfunction, acute illness/infection, injury etc):

____

____

____

Current Medication(s):

- ☐ Analgesics (pain medications).
- ☐ Non-steroidal anti-inflammatory medications (NSAIDs).
- ☐ Corticosteroids.
- ☐ Muscle relaxants.
- ☐ Anti-coagulants (blood thinners).
- ☐ Medications to address respiratory, bronchial conditions/disorders (inhalers etc.).
- ☐ Medications, recreational drugs, or substances that affect the ability to sense/experience pain.
- ☐ Medications that affect sensation; and/or
- ☐ Medications to address cardiovascular/circulatory conditions/disorders (e.g., anti-hypertensives etc.).
- ☐ Other:

____

____

____

Please initial if you are not currently taking medications: ____________

I have answered the above to the best of my knowledge and all information is accurate and current.

Signature: ____