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. If your health status changes in the future, please let your massage therapy student know.

mend
student massage clinic
at FANSHAWE COLLEGE

Health History Information – Page 1

Name: _____ Gender/Pronoun _____ Date: _____

Address: _____ Postal Code: _____ Cell Phone: _____

Work Phone: _____ Email _____ Birth date: _____

Age: _____ Height _____ Weight _____ Referred by: _____

Occupation/Area of Study: _____ Hours per week: _____

Recreational Activities: _____

_____

Family Physician: _____ Physician Phone Number: _____

Health Care: □ Chiropractor, □ Physiotherapist, □ Acupuncturist, □ Osteopath, □ Naturopath, □ Pedorthist Other_____

What is Your Opinion of Your Over-all Health: Excellent / Good / Fair / Poor

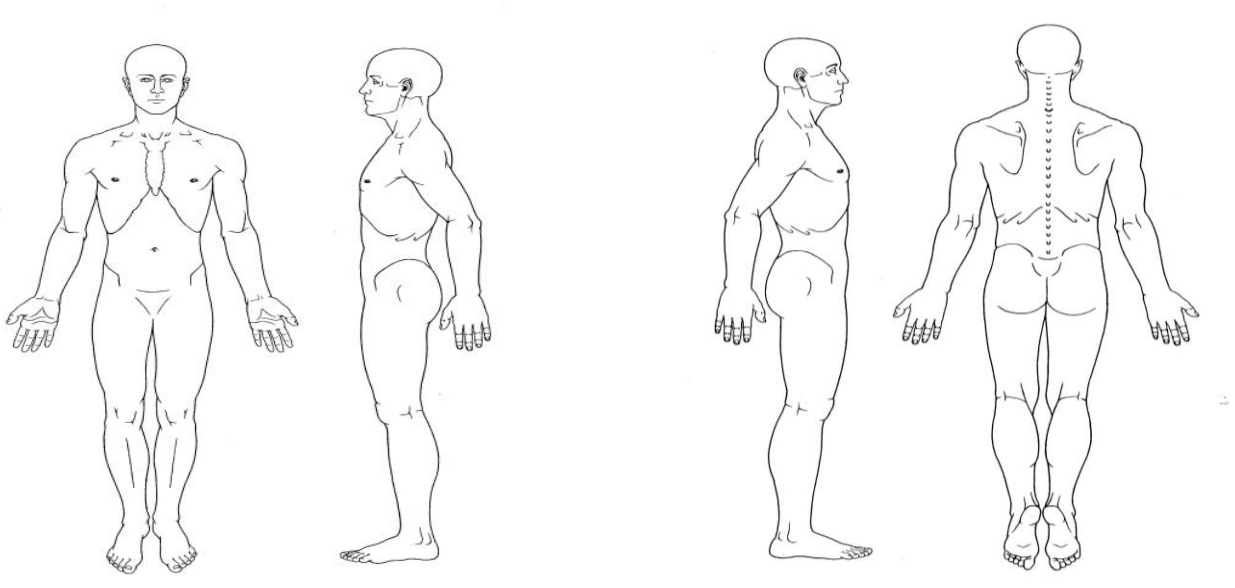
Emergency Contact's Name: _____ Emergency Contact's Phone: _____

Reason for seeking Massage Therapy: □ Relaxation □ Treatment: please state your condition here:_____

_____

What have you tried for relief? Heat □, Cold □, Exercise □, Other □ _____

Locate on the chart areas of pain and/or discomfort



Health History Information pg 2

Please indicate conditions you are experiencing, or have experienced in the past:

Head / Neck

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

Cardiovascular System

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

Nervous System

- ☐ Sensory Loss
- ☐ Numbness/Tingling
- ☐ Sciatica
- ☐ MS
- ☐ Parkinsons
- ☐ Seizures
- ☐ Paralysis
- ☐ Anxiety
- ☐ Depression
- ☐ Mental Health – Type:_____

Respiratory System

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

Immune System

- ☐ Allergies – Type: _____
- ☐ Hay fever
- ☐ Sinusitis
- ☐ Frequent Colds
- ☐ HIV/AIDS

Motor Vehicle Incident: Y N

Date _____

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

Skin

- ☐ Rashes/Eruptions
- ☐ Sensitive
- ☐ Bruise Easy
- ☐ Eczema
- ☐ Herpes
- ☐ Cold Sores
- ☐ Contagious conditions
- ☐ Lyme disease

Urinary Tract

- ☐ Kidney Stones
- ☐ Frequent Infections

General

- ☐ Fatigue
- ☐ Hepatitis
- ☐ Cancer
- ☐ Plates, Pins, Screws
- ☐ Fibromyalgia
- ☐ Left handed ☐ Right handed

Surgery / Hospitalization (type/date):

_____

_____

_____

_____

Cosmetic Procedures: (type/date):

_____

_____

_____

Gastrointestinal

- ☐ Constipation
- ☐ Liver/Gallbladder
- ☐ Heartburn
- ☐ Ulcers
- ☐ Indigestion
- ☐ Nausea
- ☐ Frequent Vomiting
- ☐ Abdominal Pain
- ☐ Diverticulitis
- ☐ Colitis

Endocrine

- ☐ Thyroid Problems
- ☐ Diabetes

Reproductive

- ☐ PMS issues
- ☐ Menopause
- ☐ Endometriosis
- ☐ Pelvic Inflammatory Disease
- ☐ Fibroids, Cysts
- ☐ Mastectomy
- ☐ Pregnant
  - # of weeks_____
  - # of children_____

Other information (yes or no)

Previous Massage Experience	**Y**	**N**
Good Sleeping habits	**Y**	**N**
Hours per night _____		
Insomnia	**Y**	**N**
Regular Exercise	**Y**	**N**
Regular Eating Habits	**Y**	**N**

Any other conditions:

_____

_____

Current Medication(s) & what it treats

_____

_____

_____

_____

_____

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: _____