Health History Form

Name:____ **Home Phone:**__________________

Address:____ **Work/Cell:**____________________

Email: ____ **DOB:**______________________

Occupation:________________________________ **Have you had Massage Therapy before? Y / N**

Family doctor (name/address)____

Are you currently receiving treatment from another healthcare professional? Y/N

If yes, for what condition/injury:____

Did a healthcare practitioner refer you for massage therapy? Y/N

Please indicate which conditions you are experiencing or have experienced in the past year.

Cardiovascular

- ☐ High blood pressure
- ☐ Low blood pressure
- ☐ Congestive heart failure
- ☐ Heart attack/Angina
- ☐ Stroke/CVA
- ☐ Heart Disease
- ☐ Pacemaker
- ☐ Varicose veins/phlebitis

Is there a family history of any of the above? Y/N

Respiratory

- ☐ Chronic cough
- ☐ Shortness of breath
- ☐ Asthma
- ☐ Bronchitis
- ☐ Emphysema

Is there a family history of any of the above? Y/N

Gastrointestinal

- ☐ Constipation
- ☐ Diarrhea
- ☐ Irritable bowel syndrome

Arthritic Conditions

- ☐ Osteoarthritis
- ☐ Rheumatoid Arthritis
- ☐ Fibromyalgia

Is there a family history of arthritis? Y/N

Infectious

- ☐ Hepatitis
- ☐ TB
- ☐ Herpes
- ☐ HIV
- ☐ Skin conditions

Neurological

- ☐ Ringing in ears
- ☐ Loss of sensation
- ☐ Numbness/tingling
- ☐ Epilepsy
- ☐ Herniated disc
- ☐ Multiple Sclerosis

Skin Conditions

- ☐ Psoriasis
- ☐ Eczema

Soft Tissue

- ☐ Muscle strain/spasm
- ☐ Muscle tension
- ☐ Sprain
- ☐ Dislocation
- ☐ Pins, wires, artificial joints

Head/Neck

- ☐ tension headaches
- ☐ Migraine headaches
- ☐ Hearing/Vision loss

Other

- ☐ Kidney disease
- ☐ Cancer ________________
- ☐ Liver disease
- ☐ Diabetes
- ☐ Allergies
- ☐ Parkinsons
- ☐ Osteoporosis

Women

- ☐ Menstrual difficulties
- ☐ Pregnancy (due:__________)

Do you have any other medical conditions? Y N

Describe:____

Please list all medications and the condition they treat

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____

Briefly list any past surgeries/traumas and when they occurred.____

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Reason for seeking treatment today:
you can use the diagram to indicate areas of discomfort

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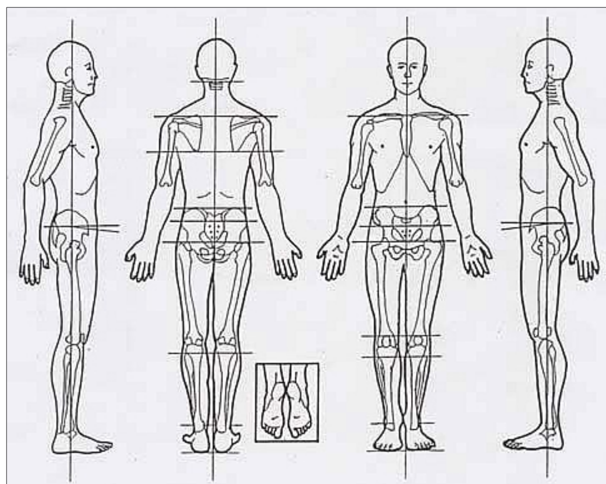

Collection of Personal Information

All client information, written and verbal, is confidential and will remain so unless authorization is obtained or disclosure is required by law.

Therapeutic Relationship

As part of our profession's on-going commitment to provide quality care, it is important that you understand your rights as a client, thereby allowing you to make informed choices regarding your massage therapy treatment.

I, the client, acknowledge my right to refuse, modify, or terminate the treatment or any aspect of it at any time.

I, the client, acknowledge the importance of providing the therapist with a current and accurate health history to receive the best treatment possible.

I, the client, acknoweldge the importance of communicating with my therapist if I feel uncomfortable with my care, my wellbeing, or my safety during my treatment.

I, the client, understand that I may make a formal complaint to the CMTO, if I feel that my therapist has caused me harm, or failed to uphold the standards of the profession.

Signature:______________________________ Date:____________________

Update 1____________________

Update 2____________________

Health and Lifestyle Intake

Name:________________________ **Date:**_________________

1. **How do you rate your current level of activity?**
   Sedentary Somewhat inactive Somewhat active Extremely active
2. **How often do you exercise and what kind of exercise do you do?**
   ____
3. **What is your CURRENT perceived stress level?** Low Moderate High
4. **What areas of your life are challenging or stressful? (**Circle all that apply)
   Personal Work Family Other
5. **Do you have a creative outlet (singing, journaling, writing, dancing, art, etc.)**
   Yes No
6. **How would you describe your breathing patterns?**
   Shallow, chest breathing Deep and rhythmic I don't think about my breath
7. **How often do you spend time outdoors?** Most Days Somedays Rarely
8. **How would you describe your overall eating habits?** Healthy Moderate Poor
9. **Do you smoke?** Yes No **Do you drink?** Yes No If yes, frequency:______________
10. **Do you wake up refreshed in the morning?** Most Days Somedays Rarely
11. **Do you have an established bedtime routine?** Yes No

For Yoga Students:

1. **Have you practiced yoga before?** Yes No
2. **How often do you practice yoga?** Daily Weekly Monthly
3. **Style(s) of yoga practiced (circle all that apply)**
   Hatha Ashtanga Vinyasa/Flow Iyengar Kundalini
   Gentle Restorative Yin Power
4. **What benefits are you looking for?** (circle all that apply)
   Strength Flexibility Balance Stress Management Posture
   Body Awareness Health Concern Injury/Rehab
5. **Personal Yoga Interests (circle all that apply):**
   Asana (postures) Pranayama (breath) Meditation
6. **Goals:**____
   ____