Ability Massage Therapy & Acupuncture Studio Confidential Health History Form

A complete health history form is essential to your massage therapist. This will ensure that it is safe for you to receive a massage therapy treatment. If your health status or personal information changes please let us know. All information gathered for this treatment is confidential, unless otherwise deemed by law, to facilitate a diagnosis or treatment plan. If this should occur then your permission (written) will be requested prior to release of information. Health history forms must be updated yearly.

Name:_____
_Date:_____
Address:_____
Postal Code:_____Date of Birth:_____Occupation:_____
Home Phone:_____Cell Phone:_____Work Phone:_____
Email:_____Extra Curricular Activities:_____

What brings you in today?_____
When did it start?_____Have you seen a doctor for this?_____
What makes it better?_____Worse?_____
When was your last massage therapy treatment?_____

Have you had or are you currently having any of the following conditions? Please mark with a ___
Please indicate your family history of the following conditions with an X

Respiratory
__chronic cough
__shortness of breath
__bronchitis
__asthma
__emphysema
__tuberculosis

Cardiovascular
__high/low blood pressure
__heart attack
__phlebitis
__stroke
__pacemaker
__heart disease
__congestive heart failure
__blood conditions
__bruise easily

__Pregnant?_____

Other
__loss of sensation/numbness
__diabetes
__allergies
__epilepsy
__cancer
__osteoporosis
__digestive conditions

Head/Neck
__vision problems
__ear/hearing problems
__headaches
__migraines
__whiplash/conditions

Infections
__hepatitis
__HIV
__herpes
__other_____

Soft Tissue/Joint Problems
__neck
__TMJ/jaw
__low back
__mid back
__upper back
__shoulders
__arms/hands
__hips
__legs/knees/feet
__arthritis
__pins / wires /artificial joints
__other_____
_____

Skin Conditions
__execema_____
__psorasis_____
__warts_____
__melanoma_____
__allergies_____

List current medications:_____
Herbal Supplements:_____

List all surgeries and dates:_____
Medical Doctor Name:_____Phone #_____
Address:_____Postal Code:_____

Are you currently seeing: Chiropractor_____Physiotherapist___Naturopath___Acupuncturist___
Nutritionist___Personal Trainer___Yoga___Pilates___
How did you find us? Road Signage:___Website:___Postcard:___Newspaper:___Social Media:___
Sporting Event:___Community Event:___Referral:_____Walk In___Other:_____