## Health History Form

A complete health history helps us ensure it is safe to provide you with a massage treatment; please let us know if your status changes so we can update your form. All information given to us is confidential.

Name ______________________ Phone ______________________

Address ______________________

Email ______________________

Date of birth ______________________

Do you see other healthcare practitioners? Chiro Physio Naturopath Osteopath Other ______________

Current Medications ______________________

Previous Major Illnesses/Operations (include dates) ______________________

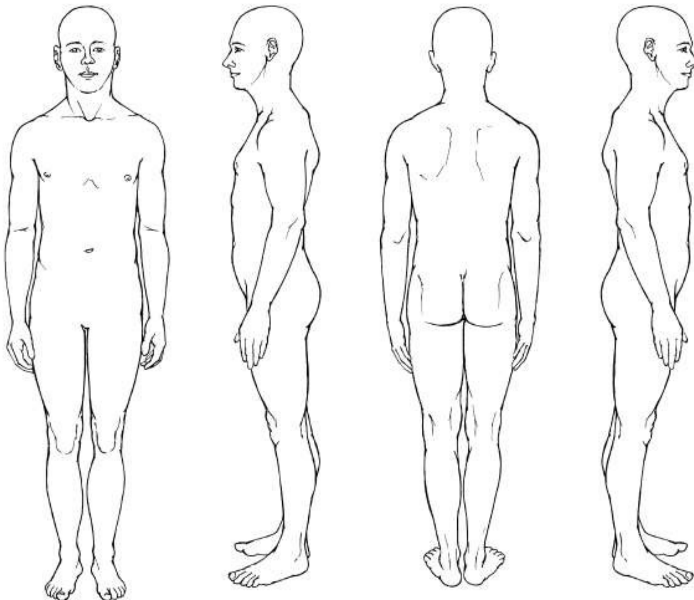
Allergies/Hypersensitivities ______________________

Family History of ______________________

Major Accidents (include dates) ______________________

Other Serious Medical Conditions ______________________

Please indicate areas you would like us to focus on and your primary area of complaint.



What is your primary complaint?

______________________

______________________

______________________

______________________

## Health History Form (please check all that apply to you)

**General Symptoms**
-  Fainting / Dizziness
-  Difficulty Sleeping / Fatigue
-  Stress
-  Headaches / Migraines
-  Nervousness
-  Numbness / Tingling; Where: ________
-  Paralysis

**Skin**
-  Rashes
-  Excessive Dryness
-  Acne
-  Psoriasis
-  Eczema
-  Skin Cancer
-  Bruise Easily

**Infections**
-  Hepatitis
-  Tuberculosis
-  HIV / AIDS
-  Herpes
-  Athlete's Foot
-  Warts

**Respiratory**
-  Chronic Cough
-  Bronchitis
-  Asthma
-  Shortness of Breath
-  Emphysema
-  Family History of ___________________

**Lifestyle (check all that apply)**

| | | | |
|---|---|---|---|
| Regular Exercise | ☐Yes | ☐No | ☐Mostly |
| Drink Plenty of Water | ☐Yes | ☐No | ☐Mostly |
| 8 Hours of Sleep nightly | ☐Yes | ☐No | ☐Mostly |
| Good Eating Habits | ☐Yes | ☐No | ☐Mostly |

What is your general health?

______________________________

**Joint / Muscle Discomfort**
-  Jaw
-  Neck
-  Shoulders
-  Arms
-  Hands
-  Upper Back
-  Mid Back
-  Low Back
-  Hips
-  Legs
-  Knees
-  Feet
-  Bursitis
-  Arthritis
-  Family History of Arthritis

**Do You Have / Had?**
-  Diabetes Onset _________________
-  Cancer; Where _________________
-  Epilepsy
-  Aneurysm / Stroke
-  Neuromuscular Conditions
-  Hypo / Hyper Glycaemic
-  Depression
-  Multiple Sclerosis
-  Thyroid Problems
-  Fibromyalgia
-  Osteoporosis
-  Mental Illness
-  Artificial Implants / Pins / Plates; Where ___________________________

**Male / Female**
-  Prostate
-  Pregnant; Due Date _______________
-  Menstrual Cramping
-  Menstrual Irregularity
-  Birth Control
-  Vaginal Pain / Infections
-  Breast Pain / Lumps
-  Menopausal

**Cardiovascular**
-  High Blood Pressure
-  Low Blood Pressure
-  Heart Attack / Disease
-  Congestive Heart Failure
-  Stroke / Aneurysm
-  Heart Murmur
-  Pacemaker
-  High Cholesterol
-  Swelling of Ankles
-  Cold Hands / Feet
-  Poor Circulation
-  Feet
-  Varicose Veins / Phlebitis
-  Family History of _________________

**Gastrointestinal**
-  Poor / Excessive Appetite
-  Excessive Thirst
-  Gas / Bloating
-  Colitis
-  Crohn's
-  Constipation
-  Diarrhea
-  Nausea / Vomiting
-  Ulcer
-  Abdominal Cramps
-  Gall Bladder Problems
-  Liver Problems

**EENT**
-  Vision Problems
-  Dental Problems
-  Sore Throat
-  Ear Aches
-  Hearing Difficulty
-  Hearing Aid
-  Stuffed Nose / Sinus
-  Allergies / Hypersensitivity to ________

Type of Reaction____________________
-  Swollen Glands

### Please read and sign:

- **I attest that the information I have provided is true and complete to the best of my knowledge.**
- **I understand the information I have provided on this form is confidential and will not be released without my written consent.**
- **I understand this treatment is strictly professional and therapeutic and inappropriate behavior will result in immediate termination of treatment and payment is due in full.**
- **I understand that bruising is a side effect of Cupping Therapy and IASTM. You release your therapist and associated business from all liability concerning any injury or damage that may occur during or after your massage.**
- **I understand a 24 hour notice is required for any rescheduling or cancellations. Failure to do so will result in full payment due.**

Signature ________________________________________________

Print ___________________________________________________

Today's Date ____________________________________________