Health History Form

An accurate health history is important to ensure that it is safe for you to receive massage therapy. All information is strictly confidential and will only be released with your written authorization.

Name:	**Occupation:**
Address:	**Date of Birth:**
City:	**Email:**
Postal Code:	**Doctor Name:**
Home Phone:	**Doctor Phone:**
Alt Phone:	**Doctor Address:**

Please indicate conditions you are experiencing or have experienced:

Cardiovascular:

- ❑ High blood pressure
- ❑ Low blood pressure
- ❑ Chronic congestive heart failure
- ❑ Heart attack
- ❑ Phlebitis/Varicose veins
- ❑ Pacemaker or similar device
- ❑ Stroke/CVA
- ❑ Heart Disease
- ❑ Lymphedema
- ❑ Cold hands/feet

Is there a family history of any of the above?

- ❑ Yes:_____
- ❑ No

Respiratory:

- ❑ Chronic Cough
- ❑ Shortness of breath
- ❑ Bronchitis
- ❑ Asthma
- ❑ Emphysema

Is there a family history of any of the above?

- ❑ Yes:_____
- ❑ No

Head/Neck:

- ❑ History of headaches
- ❑ History of migraines
- ❑ Vision problems/ loss
- ❑ Ear problems/hearing loss
- ❑ Sinus problems
- ❑ Jaw pain (TMJ)

Infectious conditions:

- ❑ Hepatitis
- ❑ TB
- ❑ HIV
- ❑ Herpes
- ❑ Athletes Foot
- ❑ Warts: Where?_____

Other Conditions:

- ❑ Loss of sensation, Where? _____
- ❑ Diabetes, Type?_____ Onset:_____
- ❑ Allergies/Hypersensitivities To what?_____ Reaction:_____
- ❑ Epilepsy
- ❑ Difficulty sleeping/insomnia
- ❑ Cancer, type?_____ Current status:_____
- ❑ Skin Conditions, What? _____
- ❑ Bruise easily
- ❑ Arthritis, Where? _____

Family history of Arthritis?

- ❑ Yes
- ❑ No

Women:

- ❑ Pregnant Due:_____
- ❑ Gynecological conditions, What?_____

General:

- **How is your overall health?** _____ _____
- **Have you received massage therapy before?**
  - ❑ Yes, Date:_____
  - ❑ No
- **What type of pressure do you like for massage?**
  - ❑ Light
  - ❑ Medium
  - ❑ Firm/deep tissue
  - ❑ I don`t know.
- **Do you like talking during your massage?**
  - ❑ Yes
  - ❑ No
  - ❑ Sometimes
- **Did a health care professional refer you for massage therapy?**
  - ❑ Yes, Who?_____ Why?_____
  - ❑ No
- **How did you hear about Revelation Massage?** _____

Do you have any other medical conditions? (e.g. Digestive, Osteoporosis, MS, Parkinsons, Fibromyalgia, Haemophilia, Mental illness)

- ❑ Yes, what?_____
- ❑ No

Do you have any internal pins, wires, artificial joints, or special equipment?

- ❑ Yes, what/where?_____
- ❑ No

Are you currently receiving treatment from another health care professional?

- ❑ Yes, for what?_____
- ❑ No

What is your **major complaint**? (ie. Areas of focus for the massage. List all.)

_____

_____

Please list ALL current **medications** and the condition being treated.

_____

_____

_____

Please list all **injuries AND surgeries** and the dates that they occurred. (ie. car accident, broken bones)

_____

_____

_____

Emergency Contact Name:_____

Relationship: **Phone Number:**

PLEASE READ CAREFULLY:

I have stated all of my medical conditions and will inform my massage therapist of **any changes** to my health status in the future.

I agree to give **24 hours notice for the cancellation** of an appointment; otherwise, I am aware I will be charged the full cost of my therapy session.

I understand that I may stop or alter my treatment at ANY time during the massage. I give my **consent** for the massage therapy treatment.

I understand that Revelation Massage Therapy & Wellness has a **privacy policy** in place and I am able to review it at any time.

_____ _____

Client Signature Date

Date of Initial Health History:	Update: