Health History Form – Massage Therapy

Full Name: _____

Date of Birth: _____

YYYY-MM-DD

Please answer the following questions to the best of your ability
Failure to do so may result in adverse or negative repercussions to the massage.

Have you had massage therapy before? Please Circle ☐ Yes ☐ No

Have you had myofascial release before? Please Circle ☐ Yes ☐ No

Do you have any of the following? Please Circle

INTERNAL PINS ☐ **WIRES** ☐ **ARTIFICIAL JOINTS** ☐ **SPECIAL EQUIPMENT** ☐

If yes and you have circled any of the above please explain what or where:_____

_____

Have you ever dislocated a joint:_____If yes which one(s) or where:

Have you had surgery:_____ If yes what for and where_____

Are you currently receiving treatment from another healthcare professional? Please Check ☐ Yes ☐ No

If yes please explain:

_____

Medication and Health

Please list all medications you may be taking and the condition(s) they are currently treating

MEDICATION	CONDITION
1.	
2.	
3.	

Have you taken any anti-inflammatory medication, pain killers, muscle relaxants, or mood altering medications within the past 2 hours? ☐ YES ☐ NO. If Yes, What and How Much?

Do you have any allergies?_____

If Yes, to what_____

Do you Bruise Easily? Please Check ☐ YES ☐ NO

Please indicate the condition that you have experienced or are experiencing

Cardiovascular

- ☐ High Blood pressure ☐ Low Blood Pressure
- ☐ Chronic congestive heart failure
- ☐ Heart attack ☐ Phlebitis/varicose veins
- ☐ Stroke/CVA ☐ Pacemaker or similar device
- ☐ Heart Disease ☐ Dizziness/Vertigo
- ☐ Seizures ☐ Other(s):

Digestive

- ☐ Constipation ☐ Crohn's Disease
- ☐ Colitis ☐ Irritable Bowel Syndrome
- ☐ Ulcers ☐ Heart Burn
- ☐ Other(s):

Head & Neck

- ☐ History of Headaches ☐ Vision Problems
- ☐ History of Migraines ☐ Loss of Vision
- ☐ Ear Problems/Loss of Hearing
- ☐ Other(s):

Infectious Conditions

- ☐ Skin Conditions, Describe:
- ☐ Respiratory Conditions, Describe:
- ☐ AIDS ☐ Herpes ☐ Hepatitis ☐ Shingles
- ☐ Other(s):

Other Conditions

- ☐ Loss of Sensation/Where?
- ☐ Hypersensitivities/Where?
- ☐ Diabetes Onset Type
- ☐ Allergies/Hypersensitivity, What to?
- ☐ Osteoporosis ☐ Scoliosis ☐ Hemophilia
- ☐ Fibromyalgia ☐ Chronic Fatigue
- ☐ Arthritis - Osteo or Rheumatoid
  Locations:
- ☐ Polio/Post Polio
- ☐ Cancer/Are you undergoing treatments
- ☐ Other(s):

Muscle and Joint

- ☐ Neck ☐ Back (Lower) ☐ Back (Middle)
- ☐ Back (Upper) ☐ Shoulders ☐ Elbow L
- ☐ Elbow R ☐ Wrist L ☐ Wrist R
- ☐ Hip L ☐ Hip R ☐ Knee L
- ☐ Knee R ☐ Ankle/Foot L
- ☐ Ankle/Foot R

Skin Conditions

- ☐ Eczema ☐ Psoriasis ☐ Rash ☐ Warts
- ☐ Open Sore ☐ Impetigo
- ☐ Other(s):

Respiratory

- ☐ Asthma ☐ Bronchitis ☐ Emphysema
- ☐ Chronic Cough ☐ Shortness of Breath
- ☐ Other(s):

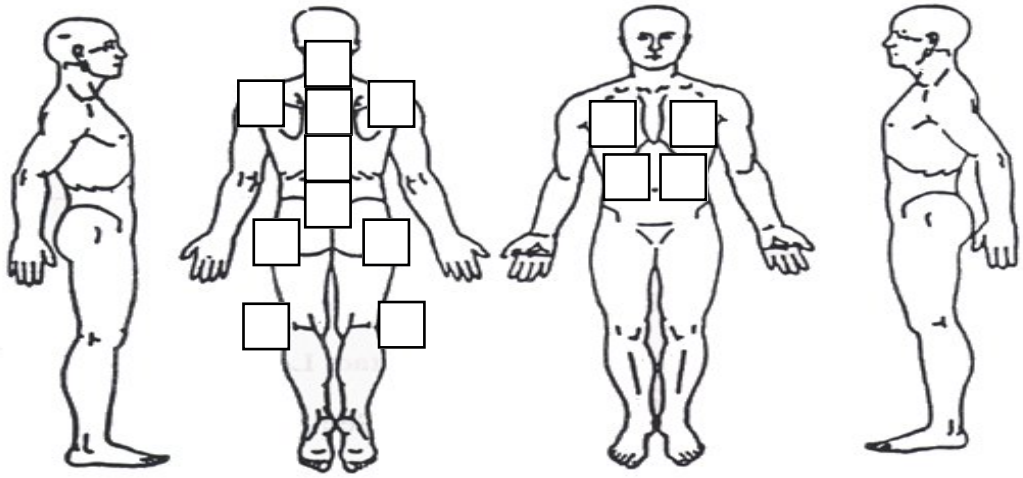
Endocrine

- ☐ Hyper/Hypo Thyroidism
- ☐ Hyper/Hypo Parathyroidism
- ☐ Crushing's Syndrome ☐ Addison's Disease
- ☐ Pituitary Diseases
- ☐ Other(s):

Women

- ☐ Pregnancy Due Date:
- ☐ Previous pregnancy complications
- ☐ Menopausal Problems
- ☐ Menstrual Problems
- ☐ Gynecological Conditions. What are they?
- ☐ Other(s):

Please Check Areas of Pain



Please outline on the diagram the area of your discomfort

Pain scale ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10

Mild Moderate

Overall, how is your Health?

Are there any conditions not stated above or any other information you would like to provide?

Informed Consent for Massage Therapy:

I attest that all the information given in the medical form above is stated to be true. I also understand that it is my responsibility to inform the Therapist of any changes in my health status.

I do hereby give consent to any and all registered massage therapists practicing at Foothills Family Chiropractic, to perform massage therapy treatments as requested. I have had an opportunity to discuss the purpose of massage therapy, and should any concerns arise at any time I will not hesitate to ask. I understand that results are not guaranteed.

I intend this consent form to cover the entire course of treatment for my present condition and for any future conditions for which I seek treatment.

Late Cancellation and No-Shows: Your appointment is valuable time that your practitioner has reserved for you. A minimum of 24-hours notice is required to cancel or reschedule appointments.

Appointments cancelled with less than 24 hours notice will be subject to a fee of 50% of treatment cost if you choose not to attend your scheduled appointment or if insufficient notice is given for a cancellation.

I have read and understand the above noted policies and consent to treatment

Patient Name (Print):

Signature: **Date:**

YYYY-MM-DD