trinity
registered massage therapy

Health History Form

Updated: Date:	Initial:
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

For Your Information:

An accurate health history is important to ensure that it is safe for you to receive a massage therapy treatment. If your health status changes, let your massage therapist know as soon as possible and this form will be updated. All information gathered for this treatment is confidential, and will only be used to facilitate a diagnosis (assessment), and treatment. You will be asked to provide written authorization for release of any information.

Personal Data:

Name: _____ Today's Date: _____

Street Address: _____ Phone# (Home): _____

City: _____ (Cell): _____

Postal Code: _____ (Work): _____

Date of Birth(mm/dd/yyyy):_____ Occupation: _____

Primary Care Physician: _____ Emergency Contact :_____

Physician's Address:_____ Phone #: _____

Email Address: _____

Who Referred you?: _____

Treatment Information:

What is your primary complaint? _____

Do you experience headaches? □ Yes □ No If yes, frequency: _____

Do you experience migraines? □ Yes □ No If yes, frequency: _____

Do you have a headache/migraine at the moment? □ Yes □ No

Have you ever received a professional massage? □ Yes □ No

What is your general health status? _____

Health History:

Current Medications: _____

Condition it treats: _____

Are you presently involved in any other health care? □ Yes □ No

If yes, please specify the type: _____

Have you ever had surgery? □ Yes □ No If yes, dates of surgery? _____

Please identify the nature of the surgery: _____

Please list any significant injuries: _____ Date of injury: _____

Have you ever been in a car accident? Yes or No If yes, date and injuries:_____

Other Medical Conditions: (e.g. digestive, gynecological, etc.)

_____

Of special note: (presence of internal pins, wires, artificial joints, special equipment)

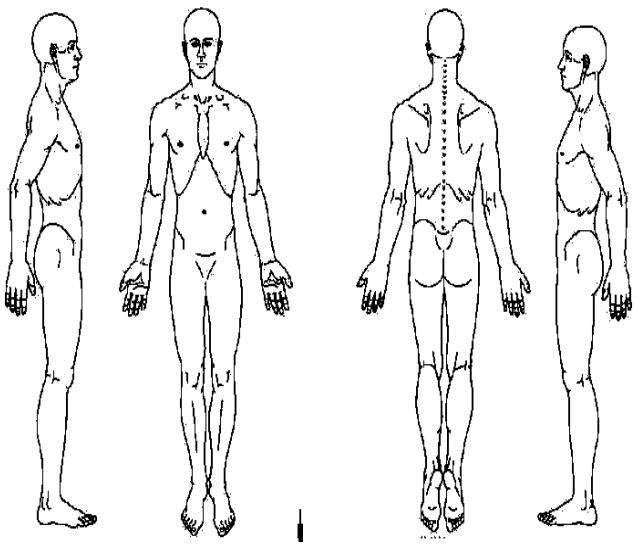
_____

Please indicate the following:

Circle areas of pain (0)

Mark an (X) over areas of stiffness/tension

Draw lines (///) over areas of numbness/tingling



SEE PAGE 2

Please check boxes of the conditions you are experiencing or have experienced:

Respiratory
- ❑ Chronic cough
- ❑ Shortness of breath
- ❑ Bronchitis
- ❑ Asthma
- ❑ Emphysema
- ❑ Sinus Problems

Cardiovascular/ Circulatory
- ❑ High blood pressure
- ❑ Low blood pressure
- ❑ Congestive heart failure
- ❑ Heart disease
- ❑ Phlebitis
- ❑ Stroke /CVA
- ❑ Pacemaker or similar device

Skin Conditions
- ❑ Skin allergies
- ❑ Bruise easily
- ❑ Rashes/eruptions
- ❑ Athletes foot
- ❑ Warts
- ❑ Eczema
- ❑ Psoriasis

General Conditions
- ❑ Epilepsy
- ❑ Hemophilia
- ❑ Depression
- ❑ Diabetes
  Type: _____
  Onset: _____
- ❑ Allergies/Anaphylaxis
  Type: _____
- ❑ Cancer: _____
  Type: _____
  Location: _____
- ❑ Arthritis: _____
  Type: _____
  Location: _____

Head/Neck
- ❑ Vision loss
- ❑ Hearing loss
- ❑ Dizziness

Infections
- ❑ Hepatitis
- ❑ Infections skin conditions
- ❑ Tuberculosis
- ❑ HIV

Nervous System
- ❑ Loss of sensation
- ❑ Chronic pain
- ❑ Numbness/tingling

Reproductive (Women)
- ❑ Pregnant
  Due Date: _____

Soft Tissue/Joint Discomfort

Check the areas where you are feeling discomfort and describe its nature
- ❑ neck _____
- ❑ low back_____
- ❑ mid back _____
- ❑ upper back_____
- ❑ shoulders_____
- ❑ arms_____
- ❑ hands_____
- ❑ legs_____
- ❑ knees_____
- ❑ feet _____
- ❑ hips _____
- ❑ other _____

Consent for Treatment:

After you complete this form, your massage therapist will review it, and conduct a brief assessment. The assessment is designed to gain pertinent information to better understand your condition. The assessment may include one or all of the following: pain questionnaires, postural analysis, range of motion tests, reflex tests, or orthopedic tests. The benefits and possible risk factors of massage therapy as well as the treatment process will be explained to you before the treatment begins. Following the treatment the massage therapist may provide you with some remedial exercises (stretches, strengthening, and/or hydrotherapy) that you can do at home to facilitate the healing process. I understand that I may change my mind regarding any aspect of my treatment at any time and upon notifying my therapist of my decision, I may withdraw consent with the intent to alter or discontinue treatment. Any information regarding your treatments and health status will not be released to any other party without your written consent.

Please check the boxes of the areas you consent to be treated *or feel free to check all of the above*:

- ❑ Back
- ❑ Hands
- ❑ Neck
- ❑ Scalp
- ❑ Shoulders
- ❑ Face
- ❑ Legs
- ❑ Buttocks
- ❑ Feet
- ❑ Chest/Pectorals
- ❑ Arms
- ❑ *ALL OF THE ABOVE*

I understand that I must give at least 24 hours notice for cancellation of an appointment in order to avoid being charged the full treatment fee. In compliance with the "Consent to treatment Act" (Bill 109), I provide my full, voluntary informed consent to apply to all present and future massage therapy treatments.

Dated this _____ day of _____, 20____. Client Signature: _____

Name (please print): _____