collaborative care
Massage Therapy for your relief and relaxation

Health History Questionnaire

The information requested below will assist us in treating you safely. Feel free to ask any questions about the information being requested. Please note that all information provided below will be kept confidentially unless allowed or required by law. Your written permission will be required to release any information.

Name:		Today's Date: D D / M M / Y Y Y Y
Address:		Apartment #:
City:	Prov.:	Postal Code:
Home Phone: ( )	Cell Phone: ( )	
Work Phone: ( )	Email:	
How would you prefer we contact/follow-up with you in the future: Home ☐ Work ☐ Cell ☐ Email ☐		
Occupation:	Date of Birth: D D / M M / Y Y Y Y	
Have you received massage therapy in the past? Y ☐ N ☐	Were you referred for massage? Y ☐ N ☐	
Please provide their name and contact information:		
What is your reason for seeking massage therapy today?		

Please indicate (✓) any conditions you currently have (C), have experienced in the past (P), or there is a family history (F) of:

CARDIOVASCULAR	C	P	F	HEAD & NECK	C	P	F	FEMALE CLIENTS	C	P	F
High Blood Pressure	C	P	F	Headaches	C	P	F	Pregnant	C	P	F
Low Blood Pressure	C	P	F	Migraines	C	P	F	Hysterectomy	C	P	F
Congestive Heart Failure	C	P	F	Hearing Loss	C	P	F	Menopause	C	P	F
Heart Attack	C	P	F	Vision Issues	C	P	F	INFECTIONS			
Stroke/Embolism	C	P	F	Vision Loss	C	P	F	Hepatitis	C	P	F
Heart Disease	C	P	F	OTHER CONDITIONS				H.I.V.	C	P	F
RESPIRATORY				Arthritis	C	P	F	Herpes	C	P	F
Chronic Cough	C	P	F	Where?				Tuberculosis	C	P	F
Bronchitis	C	P	F	Allergies	C	P	F	Psoriasis	C	P	F
Asthma	C	P	F	To what?				Is your general health good?		Y	N
Emphysema	C	P	F	Cancer	C	P	F	Current Medications:			
Sleep Apnea	C	P	F	Where?							
Shortness of Breath				Diabetes	C	P	F				
				Epilepsy							
				Loss of Sensation				Where?			
				Skin conditions				What?			

Are you currently receiving treatment from another healthcare professional? Y ☐ N ☐ If yes, what for?			
Do you have any other medical conditions? (ex. digestive, osteoporosis) Y ☐ N ☐ If yes, what?			
Do you have any internal pins, wires, artificial joints or special equipment? Y ☐ N ☐ If yes, what/where?			
Surgery:	Date:	Surgery:	Date:
Injury:	Date:	Injury:	Date:
Health History Update 1: D D / M M / Y Y	Update 2: D D / M M / Y Y		Update 3: D D / M M / Y Y
Primary Care Physician:	**Address:**		

Therapist Use Only – Additional Notes: