Priority Massage & Health
REGISTERED MASSAGE THERAPY

Health History

Name:_____ Home Phone:_____ Work :_____

Address:_____ City:_____ Postal Code:_____

Email:_____

Birthdate:_____ Weight:_____ Height:_____ Occupation:_____

Referred By:_____ General Health: ❑ Ex ❑ Good ❑ Fair ❑ Poor

Physician:_____ Physician's Address:_____

Last Physical Exam:_____ Results:_____

Main reason for treatment:_____
What have you tried for relief? ❑ Heat ❑ Cold ❑ Exercise ❑ Other_____
❑ Previous massage ❑ Regular massage Last massage date:_____

Circulation

High Blood Pressure	❑Yes	❑No
Low Blood Pressure	❑Yes	❑No
Heart Condition	❑Yes	❑No
CCHF	❑Yes	❑No
Poor Circulation	❑Yes	❑No
Dizziness	❑Yes	❑No
Pacemaker	❑Yes	❑No
Phlebitis	❑Yes	❑No
Heart Attack/Stroke	❑Yes	❑No

Digestion

Constipation/Diarrhea	❑Yes	❑No
Liver/Gail Bladder	❑Yes	❑No
Diverticulitis	❑Yes	❑No
Ulcers	❑Yes	❑No
Nausea/Gas	❑Yes	❑No

Nervous System

Nervous/Depressed	❑Yes	❑No
Fatigue	❑Yes	❑No
Insomnia	❑Yes	❑No

Respiatory

Chronic Cough	❑Yes	❑No
Shortness of breath	❑Yes	❑No
Bronchitis	❑Yes	❑No
Asthma	❑Yes	❑No
Emphysema	❑Yes	❑No
Seasonal Allergies	❑Yes	❑No

Surgery/Injury

Type_____
Date_____
Current Symptoms
_____
_____
_____
_____

Current Medications and Conditions Treated
_____
_____
_____
_____

Muscle Joints

Arthritis	❑Yes	❑No
Bursitis	❑Yes	❑No
Fractures	❑Yes	❑No
Whiplash	❑Yes	❑No
Neck Pain	❑Yes	❑No
Shoulder Pain	❑Yes	❑No
Low Back Pain	❑Yes	❑No
Mid-Upper Back Pain	❑Yes	❑No
Poor Posture	❑Yes	❑No
Stiff/Swollen Joints	❑Yes	❑No
Foot Trouble	❑Yes	❑No
TMJ	❑Yes	❑No
Knees/ Leg Trouble	❑Yes	❑No
Arm Trouble	❑Yes	❑No
Dislocated Shoulder	❑Yes	❑No
Separated Shoulder	❑Yes	❑No

Immune System

Hepatitis	❑Yes	❑No
TB	❑Yes	❑No
HIV	❑Yes	❑No
Allergies	❑Yes	❑No

Skin

Sensitive	❑Yes	❑No
Rashes/Eruptions	❑Yes	❑No
Contagious Condition	❑Yes	❑No
Other	❑Yes	❑No

Other

Loss of sensation	❑Yes	❑No
Diabetes	❑Yes	❑No
Hypoglycemia	❑Yes	❑No
Epilepsy	❑Yes	❑No
Cancer	❑Yes	❑No
Sciatica	❑Yes	❑No
Hearing Loss	❑Yes	❑No
Poor Vision	❑Yes	❑No
Internal Pins	❑Yes	❑No
Artificial Joints	❑Yes	❑No
Special Equipment	❑Yes	❑No
Headaches	❑Yes	❑No
Migraines	❑Yes	❑No

Other Heath Care

Chiropractic	❑Yes	❑No
Physiotherapy	❑Yes	❑No

Other:_____

Self Care

Good Sleeping Habits	❑Yes	❑No
Regular Exercise	❑Yes	❑No
Good Eating Habits	❑Yes	❑No
Positive Mental Attitude	❑Yes	❑No

General

Left Handed	❑Yes	❑No
Right Handed	❑Yes	❑No

For Women

PMS	❑Yes	❑No
Pregnant	❑Yes	❑No

Number of Children__

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 in the future, please let us know. All information gathered for this treatment is confidential except as required or allowed by law or except to facilitate diagnosis (assessment) or treatment. You will be asked to provide written authorization for the release of any information.

Your first consultation with the massage therapist will include a review of your health history, a postural analysis and musculoskeletal screening to determine the most effective treatment.

Proper information including potential positive and negative effects including risks and benefits associated with the massage therapy treatment will be fully discussed with you prior to initiating the treatment.

Informed Consent

I,_____ hereby consent to the massage therapy treatment as prescribed by my massage therapist. The techniques that will be used, their desired effects and possible risks have been explained to me. I am aware of my right to have my therapist modify my treatment or withdraw my consent at any time.

Privacy Act

I acknowledge that Priority Massage & Health has clearly identified to me the purposes for which my personal information is being collected and will be disclosed Priority Massage & Health during the proceedings in connection with this matter. I consent to the collection, use and disclosure of my personal information for the purposes of massage therapy and acknowledge that my personal information will not be used or disclosed for any other purpose without my prior consent to do so.

I have read and understand the above information and consent to treatment.

Name_____

Signature_____ Date_____