

JASON'S

— MOBILE MESSAGE THERAPY —

Health History Form

Name: _____ Phone #: _____
 Address: _____ City: _____
 Occupation: _____ Date of birth: _____

The information requested below will assist us in treating you safely. This form must be filled in completely prior to meeting with your RMT. Please don't hesitate to ask any questions about the information being requested.

Have you ever received massage therapy before? Yes No
 Did a health care practitioner refer you for massage therapy? Yes No
 If yes, please provide their name and 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
- stroke / CVA
- pacemaker or similar device
- heart disease

is there a family history of any of the above?
 Yes No

Respiratory

- chronic cough
- shortness of breath
- bronchitis
- asthma
- emphysema
- C.O.P.D.

is there a family history of any of the above?
 Yes No

Infections

- hepatitis
- skin conditions
- TB
- HIV
- herpes
- warts or fungus

Other conditions

- loss of sensation, where? _____
- diabetes, onset: _____
- allergies / hypersensitivity to what? _____
 _____ reaction? _____
- epilepsy
- cancer, where, when? _____
- _____
- are you currently cancer free? _____
- skin conditions, what? _____
- arthritis

is there a family history of any of the above?
 Yes No

Head / neck

- history of headaches
- history of migraines
- vision problems
- vision loss
- ear problems
- hearing loss

Overall

How is your general health? _____

Primary care physician: _____
 Address: _____

Female Only

- pregnant, due? _____
- gynecological conditions, what? _____

Current Medications: _____ condition it treats: _____

Are you currently receiving treatment from another health care professional? Yes No for what? _____

Surgery - date: _____ nature: _____

Injury - date: _____ nature: _____

Do you have any other medical conditions? (e.g digestive conditions, haemophilia, osteoporosis, mental illness) Yes No
 what? _____

Do you have any internal pins, wires, artificial joints or special equipment? Yes No
 what? _____ where? _____

Note: A review and discussion of your health history form will be part of your treatment time.