AMANDA LACEY

MOBILE RMT

MASSAGE

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.