Client Health History Form

General Information

Name ___________________________________ Male Female

Address _______________________________ City _________________ Prov_______ Postal Code __________________

Birth Date _____/_____/_______ Phone ______________________ Email ___________________________________

Occupation _______________________________ How did you hear about us? _______________________________

Have you had massage in the past? Yes No

Medical History

Primary reason for your visit ____

Have you seen any other health care professional(s) for this condition or reason?
 Yes No ____

Any Surgeries, injuries or car accidents? Yes No If yes, please list:
____
____

Do you have any allergies? Yes No ____

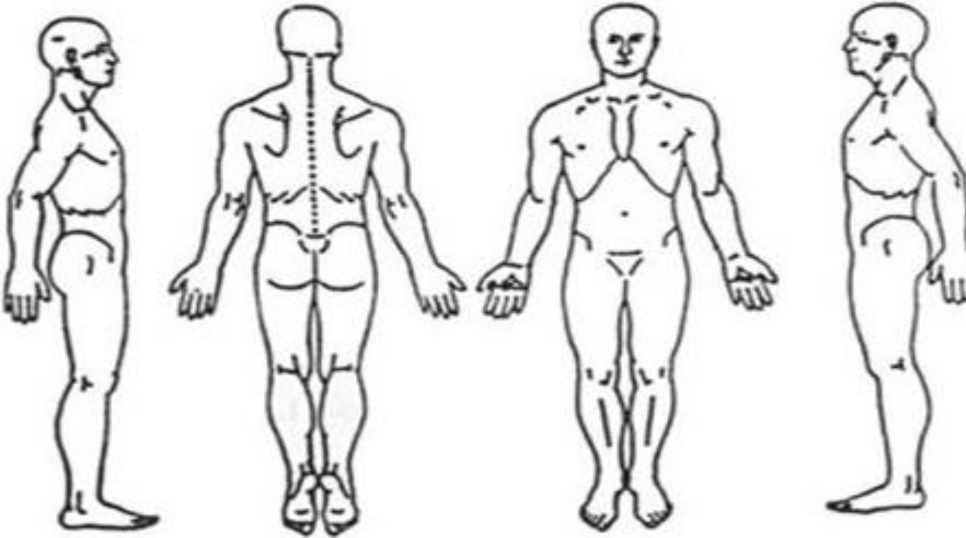
Are you presently taking any prescribed medication(s)? Yes No
If yes, please list the medication(s) and the condition(s) for which it is being used
_______________________________________ ____
_______________________________________ ____

Women
Are you currently pregnant? Yes No If yes, how many months?______

Therapist Notes:

____
____
____
____
____
____
____

Circle any areas of pain or discomfort



If pain is present, would you describe it as:

Sharp

Shooting

Dull ache

Pain on movement

Local

Referring

Check any that apply:

O High blood pressure
O Low blood pressure
O Congestive heart failure
O Heart attack
O Varicose veins
O Stroke
O Heart disease
O Headaches
O Migraines
O Vision problems
O Hearing problems
O Dizziness
O Constipation
O Crohn's Disease
O Colitis

O Eczema
O Psoriasis
O Rash: ______________________________
O Warts: _____________________________
O Open Sores/cuts: ____________________
O Osteoporosis
O Arthritis
O Osteoarthritis
O Fractures: _______________________
O Wires/Plates/Pins: ________________
O Fibromyalgia
O Chronic fatigue
O Cancer
O Diabetes - Type 1 Type 2
O Epilepsy
O Other: ____________________________________

I acknowledge that the Massage Therapist is not a physician and does not diagnose illness or disease or any other physical or mental disorder. It is recommended that I attend my personal physician for any ailment that I may be experiencing which is out of the massage therapists scope of practice. I acknowledge that no assurance or guarantee has been provided to me as to the results of the treatment. I release the massage practitioner from any and all liability from problems arising from the treatment as a result of information not given, or incorrectly given in this patient history. Because my personal and medical information is confidential, I understand that this information will only be seen by practitioners employed at Temple Therapeutics.

Signature _____________________________________ Date ____________________

Signature of Parent or Guardian if Client is under 18 years of age

Signature _____________________________________ Date ___________________