Results 360

HEALTH HISTORY

An accurate health history form is important to ensure that it is safe for you to receive a massage treatment. If your health status changes at any time, please let us know. All information 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 prior to release of any information. All information is safeguarded from loss, theft, or unauthorized access. At your request, you may have access to any information in your file.

Name: ____ **Today's Date**: _________________

Address: ____ **Date of Birth**: _________________

City: ________________________ **Postal Code**:__________ **Occupation**: __________________

Home Phone: **(____)**_____________ **Cell Phone**: (___)___________ **Work Phone**: ___________________

Email: ________________________ **Physician**: _____________________

Insurance Company _____________________________ **Medicare #**_____________________

Have you had massages in the past? ______________

Primary Complaint:____

Please check any of the following that you are experiencing or have experienced:

SKIN

__Rashes/Bruise Easily

__Infectious skin conditions

If so, what? _________

Other?_____________

MUSCLE/JOINTS

__Neck

__Upper back

__Mid back

__Lower back

__Shoulder

__Elbow

__Arm

__Wrist

__Hand

__Hip

__Knee

RESPIRATORY

__Asthma

__Bronchitis

__ Chronic Cough

__ Pneumonia

__ Emphysema

__ Shortness of Breath

__Difficulty Breathing

Other:_____________

CARDIOVASCULAR

__ Bleeding disorder

__High Blood Pressure

__Low Blood Pressure

__Heart Attack

__Heart Disease

__Angina

__Stroke

GI CONDITIONS

__Constipation

__Diarrhea

__Irritable Bowel

__ Hiatus Hernia

__Ulcers

Other:____________

OTHER CONDITIONS

__Thyroid: Hyper/Hypo

__ Diabetes

__Fever

__Fainting

__Insomnia

__Stress

__Allergies:___________

__Seizures: ___________

__Cancer:____________

__Leg
__Ankle
__Foot
__Weakness:____________
__Numbness:____________
__Tingling:______________
__Osteoarthritis:____________
__Rheumatoid Arthritis:__________
__Tendinitis:_________________
__Joint Sprain/Dislocation:___________

OTHER INJURIES:__________________

MOTOR VEHICHLE ACCIDENT:_______

When:____________________________

__Pacemaker
__Varicose Veins
__Phlebitis
__Poor Circulation
Other:_____________

HEAD/NECK

__Visual Impairment
__Hearing Impairment
__Speech Impairment
__Headaches/Migraines
__Jaw Pain/TMJ
__Sinus Problems

Other:_______________

INFECTIOUS DISEASE

__Hepatitis:________
__HIV/Aids:________
__Herpes:___________
__Tuberculosis:______

FRACTURE

Yes: Location:_______
When:__________

PREGNANCY

Due Date:__________
Complications:_________

CURRENT MEDICATIONS:____

____

PAST SURGERY

Date:________________ Surgery:____

Date:________________ Surgery:____

Date:________________ Surgery:____

POLICIES

Cancellation/No Show Fee: Must give 4 hours notice of cancellation. Failure to Cancel or No Show will result in a full treatment fee.

PAYMENT OPTIONS: Please have cash or cheque. No debit or credit cards can be accepted.

I___________________________________ understand all the risks and side affects of Massage Therapy and agree to abide by the above policies. I also verify that the information given on this form accurately reflects my past and present health status; I will continue to update the Massage Practitioner of any changes to my health.

Signature:____________________________________ Date:______________________