Massage Therapy Heath History Form

Patient Name (Please Print)	Birthdate (dd/mm/yyyy)	MSP#
Address		City
Prov / State	Postal Code	Email
Phone number (home)	Phone number (cell or work)	Best time to call
Occupation	How did you hear about us?	
Emergency Contact	Relation	Phone number
ICBC Claim (yes or no)	Date of Injury (if applicable)	

Please list other health professionals you are currently seeing (complimentary and conventional) and their contact numbers. Include their area of practice (GP, Chiropractor, ect.) ________________________________

____

Primary concern: ________________________________

____

How long? ____________

____

When did it start? ____________

____

What aggravates the condition?

____

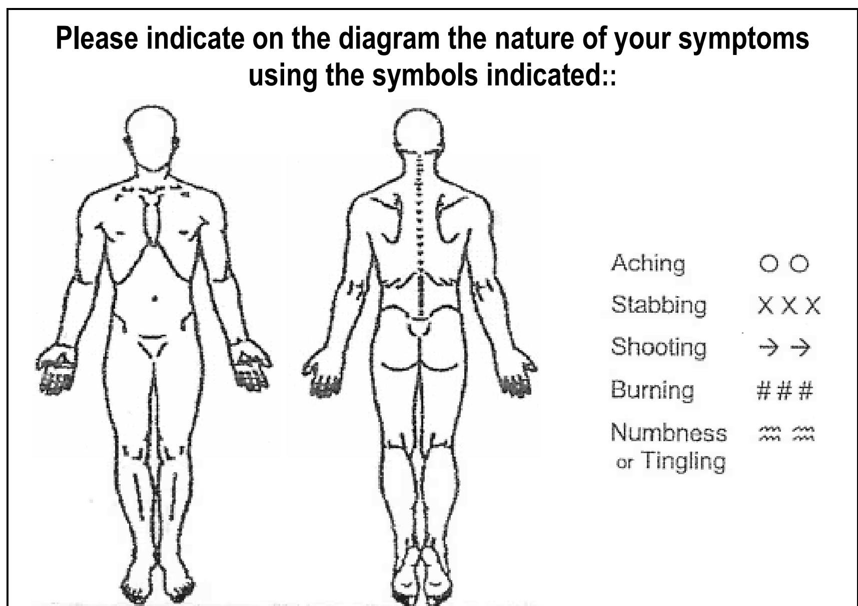
____

What relieves the condition?

____

____

Please indicate on the diagram the nature of your symptoms using the symbols indicated::



Warmland Massage Therapy
306 Duncan St, Duncan, BC
warmlandmassagetherapy.com

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Medications you are presently taking: ____

____

Surgeries, major injuries or accidents you have had: ____

____

Known Allergies: ____

____

Please rate the following (circle the appropriate value)				
Stress level	None	Slight	Moderate	Severe
Physical Activity	None	Low	Moderate	High
Diet	Poor	Average	Good	Excellent
Sleep and Energy Levels	Poor	Average	Good	Excellent

List any activities, sports or hobbies (i.e. Jogging, Hockey, Curling, Weaving ect.): ____

____

____

Please circle and place a C (current) or P (past) on any of the following conditions that apply to you		
Heart Condition	Circulatory Disorder	Menstrual Problems
Osteoporosis	Stroke (CVA)	High/Low Blood Pressure
TMJ Syndrome	Pregnancy	Seizures
Fibromyalgia	Contagious Condition	Arthritis
Headaches/Migraines	Nausea	Loss of Sensation/Tingling
Tumors/Cysts	Dizziness/Vertigo	Spinal Injury
Fractures/Dislocations	Backaches	Varicose Veins
Bruises Easily	Cancer	Diabetes

Other Conditions: ____

____

____

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