My Massage Therapist, 6139 Main Street, Stouffville, ON, L4A 3R6, (647)400-6547

HEALTH HISTORY FORM

The information requested below will assist un treating you safely. Feel free to ask any questions about the information being requested. Note that all information provided below will be kept confidential unless allowed or required by law. Your written permission will be required to release any information to a third party.

Name:_____ **Date of Birth:**_____

Address:_____ **Occupation:**_____

Phone/Cellular:_____ **Referred by:**_____

Email:_____ **Doctor's Name/Town:**_____

Have you received massage therapy before? _____ **Do you use text messaging? _____**

Please note that a 24 hour cancellation policy is in effect and will be enforced at the discretion of the therapist. Kindly phone, email or send a text message to make any changes to your appointment 24 hours in advance if possible or a $40 fee will be charged at the time of your next visit.

Signature:_____ **Date:**_____

☐ Headaches
☐Migraines
☐Vision loss/problems
☐Hearing loss/problems
☐Dizziness
☐Sinus pain

Heart:

☐ High/low blood pressure
☐Congestive heart failure
☐Heart attack
☐Phlebitis/varicose veins
☐Stroke/CVA
☐Pacemaker
☐Heart disease
☐Raynaud's

Respiratory:

☐Chronic cough
☐Shortness of breath
☐Bronchitis
☐Asthma
☐Emphysema

Infections:

☐Hepatitis
☐TB
☐HIV
☐Herpes/cold sores/shingles

Skin:

☐Excema
☐Psoriasis
☐Bruises easily
☐Poor healing

Other:

☐Allergies
☐Diabetes
☐Hypoglycemia
☐Epilepsy
☐Cancer
☐Arthritis
☐Constipation
☐Insomnia
☐Fibromyalgia
☐Hyper/hypothyroid

MUSCULOSKELETAL:

☐**PAIN**
☐**SWELLING**
☐**STIFFNESS**
☐**NUMBNESS**
☐**TINGLING**

In the:

☐Neck
☐Shoulder left/right
☐Arm left/right
☐Upper back
☐Mid back
☐Lower back
☐Leg left/right
☐Knee left/right
☐Foot left/right

Women:

Due date if pregnant:_____
Gynecological issues:_____

Men and Women:

Medic Alert?:_____
Good general health?_____

MEDICATION:_____ **OTHER HEALTH CARE (chiro/physio…)**_____

INJURY/SURGERY:_____ **DATE OF MOST RECENT DOCTOR'S VISIT:**_____

_____ **REASON FOR MASSAGE:**_____

_____ _____

PINS/WIRES/JOINTS:_____ _____

Your information is protected under the Privacy Act. Files are the property of My Massage Therapist/Sheila Graham, RMT, Sole Owner/Therapist.