HEALTH HISTORY FORM

Regent Massage

An accurate health history is important to ensure that it is safe for you to receive a massage treatment. All information gathered for this treatment is confidential except as required or allowed by law. Written authorization will be required for release of any information.
This form must be updated annually.

First Name: ____________________ **Last Name:** ____________________
(this is how your name will appear on your receipt)

Address: ____________________ **Tel. Home:** ____________________

City: ________ **Postal Code:** ________ **Tel. Cell:** ____________________

Date of Birth: DD / MM / YY **Gender: M / F**

Occupation: ____________________ **Email:** ____________________

Primary Health Care Physician: ____________________

Address: ____________ **Tel No:** ____________

❑ **Health Practitioner's Referral:** ____________________
Address of Health Practitioner: ____________________
❑ **Others Referral:** ____________________

Emergency Contact Person: ____________________ **Emergency Contact Person Tel:** ____________________

1st Massage Therapy Treatment: Yes/No **General Health Status:** ____________________

Primary Complaint: ____________________

How did you first hear about Regent Massage? ____________________

Health History: Please indicate ☑ conditions you are experiencing, present or past.

Soft Tissue/Joints
(Specify its nature: Pain, Stiffness, Numbness, Twitching, etc)

	Present	Past
❑ neck	______	______
❑ shoulder	______	______
❑ upper back	______	______
❑ mid back	______	______
❑ low back	______	______
❑ arms	______	______
❑ chest	______	______
❑ legs	______	______
❑ knees	______	______
❑ hips	______	______
❑ other	______	______

History Headaches

- ❑ tension
- ❑ migraines
- ❑ tooth/jaw/ear pain
- ❑ head trauma/date: ____________
- ❑ history of headaches/type: ________
- ❑ other: ____________________

ACCIDENT/INJURY

❑ Car Accident ❑ Work Related ❑ Other

Date: ____________

Symptoms: ____________________
____
____
____

Physical Limitations: ____________________
____
____
____

Respiratory

- ❑ chronic cough
- ❑ shortness of breath
- ❑ bronchitis
- ❑ asthma
- ❑ emphysema
- ❑ pneumonia
- ❑ sinus problems
- ❑ family history of any of above

Cardiovascular

- ❑ high blood pressure
- ❑ low blood pressure
- ❑ heart attack (date:__________)
- ❑ phlebitis / DVT
- ❑ stroke / CVA (date:__________)
- ❑ pulmonary emboli
- ❑ pacemaker
- ❑ heart disease
- ❑ angina
- ❑ chronic congestive heart failure
- ❑ family history of any of above

Infectious Disease

- ❑ hepatitis
- ❑ infections skin conditions
- ❑ tuberculosis
- ❑ HIV
- ❑ other: ____________________

Gastroinstestinal

- ❑ irritable bowel syndrome
- ❑ colitis
- ❑ gastroenteritis
- ❑ crohn's disease
- ❑ constipation

Skin

- ❑ skin condition
  specify ____________________
- ❑ bruise easily
- ❑ herpes
- ❑ varicose veins
- ❑ athletes foot
- ❑ loss of sensation

Other Conditions

- ❑ neurological conditions ________
- ❑ epilepsy
- ❑ diabetes/onset: ____________
- ❑ allergies: ____________________
  (❑ anaphylaxis; ❑ skin irritations)
- ❑ family history of allergies
- ❑ family history of hypersensitivities
- ❑ cancer ____________________
- ❑ arthritis ____________________
  type OA/RA/other: ____________
  where ____________________
- ❑ family history of arthritis
- ❑ vision loss
- ❑ hearing loss
- ❑ insomnia
- ❑ haemophilia
- ❑ kidney/bladder problems
  (❑ dialysis)
- ❑ overactive bladder
- ❑ osteopenia
- ❑ osteoporosis
- ❑ positional vertigo
- ❑ mental illness: ____________
- ❑ other: ____________________

Please continue on the next page…

Regent Massage

Women

- ❑ pregnant / due date: _DD_/_MM_ /_YY_
- ❑ gynecological conditions: ____________________
- ❑ breast pain
  - o cysts
  - o breast lift (date): _DD_/_MM_ /_YY_
  - o breast augmentation (date): _DD_/_MM_ /_YY_
  - o breast reduction (date): _DD_/_MM_ /_YY_

Surgery

type ____

date: _DD_/_MM_ /_YY_

current symptoms ________________________________

____

____

____

____

____

Current Medications and Conditions

____

____

____

____

____

❑ **Present involvement in other Health Care: Yes/No**

If Yes Specify: ________________________________

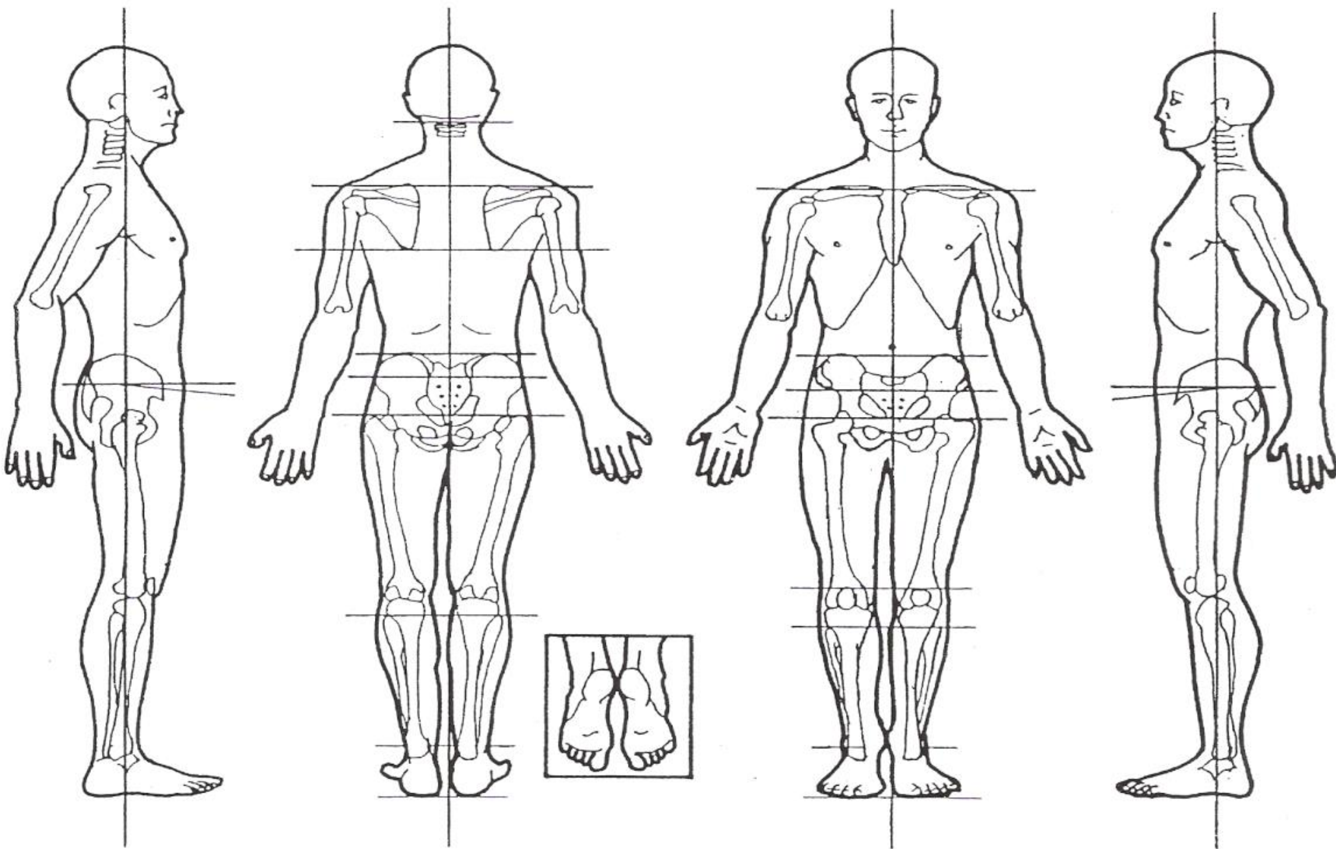
❑ **Pins / Wires/ Prosthetics:** ______________________

❑ **Medical Alert Bracelet** (specify condition / allergy)

____

____

Please indicate the location of any tissue or joint discomfort



Signature: ____ **Date:** ____

UPDATED

Date: ______________________________

Date: ______________________________

Date: ______________________________

Date: ______________________________

Exercise

- ❑ none
- ❑ moderate
- ❑ daily
- ❑ heavy

Work activity

- ❑ sitting
- ❑ standing
- ❑ light labor
- ❑ heavy labor

Habits

- ❑ smoking
- ❑ coffee
- ❑ caffeine drinks
- ❑ high stress level