

Ken Shim, RMT – Health History Form

An accurate health history is important to ensure that it is safe for you to receive a massage treatment. If your health status changes in the future, please inform your therapist. All information gathered for this treatment 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 for release of any information.

PERSONAL INFORMATION

Name: _____ Today's Date _____
 Phone (Home) _____ (cell) _____ Date of Birth _____
 (Work) _____ Primary Complaint _____
 Address _____ Occupation _____
 City _____ Postal Code _____ Physician & Address _____
 Email _____ Who referred you? _____

HEALTH HISTORY

Please indicate all current and past conditions you have experienced.

Head/Neck	Current	Past	Respiratory/Lungs	Current	Past	Digestive	Current	Past
Whiplash	<input type="checkbox"/>	<input type="checkbox"/>	Asthma	<input type="checkbox"/>	<input type="checkbox"/>	Constipation	<input type="checkbox"/>	<input type="checkbox"/>
Headache	<input type="checkbox"/>	<input type="checkbox"/>	Bronchitis	<input type="checkbox"/>	<input type="checkbox"/>	Diarrhea	<input type="checkbox"/>	<input type="checkbox"/>
Migraine	<input type="checkbox"/>	<input type="checkbox"/>	Emphysema	<input type="checkbox"/>	<input type="checkbox"/>	Crohn's Disease	<input type="checkbox"/>	<input type="checkbox"/>
Concussion	<input type="checkbox"/>	<input type="checkbox"/>	Shortness of breath	<input type="checkbox"/>	<input type="checkbox"/>	Irritable Bowel Syndrome	<input type="checkbox"/>	<input type="checkbox"/>
Ringing in the ears	<input type="checkbox"/>	<input type="checkbox"/>	Chronic cough	<input type="checkbox"/>	<input type="checkbox"/>	Ulcers	<input type="checkbox"/>	<input type="checkbox"/>
Hearing loss	<input type="checkbox"/>	<input type="checkbox"/>	Other:	<input type="checkbox"/>	<input type="checkbox"/>	Diverticulitis	<input type="checkbox"/>	<input type="checkbox"/>
Vision problems	<input type="checkbox"/>	<input type="checkbox"/>	Is there a family history of any of the above?			Nausea	<input type="checkbox"/>	<input type="checkbox"/>
Brain injury	<input type="checkbox"/>	<input type="checkbox"/>				Other:	<input type="checkbox"/>	<input type="checkbox"/>
TMJ (Jaw Pain)	<input type="checkbox"/>	<input type="checkbox"/>						
Other:								

Cardiovascular	Current	Past	Nervous System	Current	Past	Infections	Current	Past
High blood pressure ____/____	<input type="checkbox"/>	<input type="checkbox"/>	Spinal cord injury	<input type="checkbox"/>	<input type="checkbox"/>	Hepatitis	<input type="checkbox"/>	<input type="checkbox"/>
Low blood pressure ____/____	<input type="checkbox"/>	<input type="checkbox"/>	Seizures/Epilepsy	<input type="checkbox"/>	<input type="checkbox"/>	Type:		
Heart attack	<input type="checkbox"/>	<input type="checkbox"/>	Numbness/Tingling	<input type="checkbox"/>	<input type="checkbox"/>	Infectious skin		
Chronic congestive heart failure	<input type="checkbox"/>	<input type="checkbox"/>	Where?			conditions	<input type="checkbox"/>	<input type="checkbox"/>
Stroke/CVA	<input type="checkbox"/>	<input type="checkbox"/>	Other:			Type?		
Pacemaker or similar device	<input type="checkbox"/>	<input type="checkbox"/>	Artificial Joints, plates, pins			TB	<input type="checkbox"/>	<input type="checkbox"/>
Phlebitis/Varicose veins	<input type="checkbox"/>	<input type="checkbox"/>				HIV	<input type="checkbox"/>	<input type="checkbox"/>
Heart Disease	<input type="checkbox"/>	<input type="checkbox"/>				Herpes	<input type="checkbox"/>	<input type="checkbox"/>
Other:						Other:		
Is there a family history of any of the above?								

Disease/condition	Current	Past	WomenOnly	Current	Past	Bone/Joint	Current	Past
Cancer _____	<input type="checkbox"/>	<input type="checkbox"/>	Pregnancy	<input type="checkbox"/>	<input type="checkbox"/>	Dislocation/Fracture	<input type="checkbox"/>	<input type="checkbox"/>
Diabetes _____	<input type="checkbox"/>	<input type="checkbox"/>	Vaginal Birth/abortion		<input type="checkbox"/>	Osteoarthritis	<input type="checkbox"/>	<input type="checkbox"/>
Treatment:	<input type="checkbox"/>	<input type="checkbox"/>	Due Date:			Rheumatoid Arthritis	<input type="checkbox"/>	<input type="checkbox"/>
Fibromyalgia	<input type="checkbox"/>	<input type="checkbox"/>	Current gynaecological conditions:			Degenerative disc disease	<input type="checkbox"/>	<input type="checkbox"/>
Chronic Fatigue Syndrome	<input type="checkbox"/>	<input type="checkbox"/>				Herniated disc	<input type="checkbox"/>	<input type="checkbox"/>
Allergies _____	<input type="checkbox"/>	<input type="checkbox"/>				Other:		
Other								

Accidents/Injuries/Operations	Year	Accidents/Injuries/Operations	Year

Current medications and the conditions they treat: _____

For your current condition, have you tried any of the following (Use an 'X' if it was unsuccessful or a '✓' if it was successful):

Massage Chiropractic Physiotherapy Acupuncture Osteopath Yoga Pilates Stretching & Exercise

Are you physically active? Yes No

How often? _____

Type of exercise: _____

Previous massage experience: Yes No

Good sleeping habits: Yes No

Regular eating habits: Yes No

Current Symptoms:

1. On the diagram, use the following letters to indicate the locations of your pain:

A - Ache/Dull pain P - Pins & Needles/Tingling
 B - Burning N - Numbness

2. Beside each letter, mark the intensity of pain with a number from 1 to 10 (i.e. 0 - no pain, 10 - child birth)

What is your general level of pain **now** (0 – 10)? _____

What is the level of your pain at its worst (0-10)? _____

How often do you feel the pain? _____

When did the pain start? _____

What caused it? _____

What movements or activities make the pain worse? _____

What relieves the pain? _____

What has the pain stopped you from doing? _____

What goals do you want massage therapy to accomplish for you? _____

List any areas that you do not want treated: _____

Date _____

Client's Signature _____

Date _____

Therapist's Signature _____

Update 1 _____

Update 2 _____

Update 3 _____

Update 4 _____

