Cindy Adams, RMT

Health History

An accurate health history is important to ensure that it is safe for you to receive a massage treatment. Feel free to ask any questions about the information being requested. If your health changes in the future, please let us know. All information gathered for this treatment is confidential unless allowed or requested by law. You will be asked to provide written authorization for release of any information.

Name:_____ **Phone #:**_____
Address:_____
Occupation:_____ **Date Of Birth:**_____
Email:_____
Have you received massage therapy before? Yes___ No____
Did a health care practitioner refer you for massage therapy? Yes____ No____

Please indicate conditions you are experiencing or have experienced (past 10 years)

Muscle/Joint

_____Headaches/Migraines
_____Head Trauma/Concussion
_____Neck Pain/Injury
_____Whiplash
_____Back Pain/Weakness
_____Shoulder Pain/Injury
_____Arm Pain/Weakness
_____Hip Pain/Sciatica
_____Leg Pain/Weakness
_____Knee Pain/Injury
_____Foot Pain/Injury
_____Tendonitis
_____Bursitis
_____Gout
_____Swelling
_____Limited Movement/Stiffness
_____Dislocation/Fractures

Respiratory

_____Asthma/Bronchitis
_____Chronic Cough
_____Frequent Colds
_____Shortness of breath
_____Allergies/Sinus Problems
_____Emphysema
_____Pneumonia

Cardiovascular

_____High/Low Blood Pressure
_____Heart Attack/Stroke
_____Heart Disease
_____Phlebitis/Varicose Veins
_____Rapid/Slow Heartbeat
_____Hardening of Arteries
_____Chest Pain/Angina
_____Cold Hands/Feet
_____Pacemaker
_____Hemophilia

Contagious

____HIV/AIDS
____Hepatitis A/B/C
____Tuberculosis
____Skin Condition

Gynecological

____Currently Pregnant
____PMS
____Menopause

Eyes/Ears/Throat

_____Dizziness
_____Blurred Vision/Vision Problems
_____Tinnitus
_____Hearing Loss
_____Recent Dental Work
_____TMJ/Jaw Cracking
_____Clenching/Grinding Teeth

Gastrointestinal

_____Nausea/Vomiting
_____Constipation/Diarrhea
_____Ulcers
_____Hiatus Hernia
_____IBS
_____Crohn's/Colitis
_____Diverticulitis
_____Gallbladder Problems

Skin

_____Rash/Hives
_____Sensitive
_____Cold Sores
_____Bruise Easily

Genitourinary

_____Painful/Frequent Urination
_____Kidney/Gallstones
_____Kidney/Bladder Infection
_____Incontinence

Other Conditions/Injuries/Illnesses

_____Poor Healing/Bruising
_____Diabetes
_____Anemia
_____Fatigue
_____Loss of Sensation
_____Epilepsy
_____Arthritis RA/OA
_____MS
_____Fibromyalgia
_____Osteoporosis
_____Degenerative/Prolapsed Discs
_____Scoliosis
_____Thyroid
_____Mental Illness
_____Stress
_____Cancer
_____Depression

Current Medications/Supplements/Herbs: _____

Surgical Operations: _____

Major Injuries/Accidents: _____

Pins/Wires/Plates/Artificial Joints: _____

I have read and understood the information my therapist has given me. I have had the opportunity to ask questions and I verify that all information provided is accurate and complete and I consent to treatment: _____

Date: _____