

## Health History Form

Thank you for filling out this confidential form. It allows us to design a safe and effective treatment for you, working toward your health goals. As our privacy policy explains, we will not release any of this information without your consent except as required by law. If any of your health or contact information changes in the future, please let us know so that we can continue to work together safely and effectively.

Name \_\_\_\_\_ Date \_\_\_\_\_

Phone (day) \_\_\_\_\_ (eve) \_\_\_\_\_ (cell) \_\_\_\_\_

Address \_\_\_\_\_ City \_\_\_\_\_ Postal Code \_\_\_\_\_

E-mail \_\_\_\_\_ Birth date \_\_\_\_\_

Emergency contact name \_\_\_\_\_ Phone \_\_\_\_\_

How did you hear about Body Poets? \_\_\_\_\_

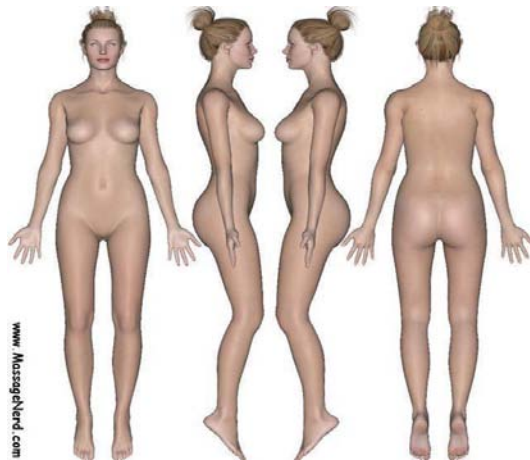
Did a health care provider refer you?  Yes  No Have you received massage therapy before?  Yes  No

May we send you our quarterly email-newsletter?  Yes  No

**“If I decide to receive treatment from more than one therapist at Body Poets Massage Therapy, I agree to my health information being shared between my therapists.”**  Yes  No

WHY would you like massage therapy today? \_\_\_\_\_

Please circle any areas of your body where you would like to feel more comfortable today:



Please list all the treatments or medications you have used or taken in the last 24 hours:

Any other medications you are currently taking and the conditions they treat

History of accidents and injuries (e.g. serious sprain, serious fall, motor vehicle accident)

History of surgery

Name and location of primary health care provider

Other health care you are currently using

**Please complete back of form**

Please check all of the following conditions that affect you:

<p><b>Cardiovascular</b></p> <ul style="list-style-type: none"><li><input type="checkbox"/> Chronic congestive heart failure</li><li><input type="checkbox"/> Heart attack</li><li><input type="checkbox"/> Heart disease</li><li><input type="checkbox"/> Blood pressure: high or low</li><li><input type="checkbox"/> Pacemaker or similar device</li><li><input type="checkbox"/> Phlebitis or varicose veins</li><li><input type="checkbox"/> Stroke/CVA</li></ul> <p><b>Respiratory</b></p> <ul style="list-style-type: none"><li><input type="checkbox"/> Asthma</li><li><input type="checkbox"/> Bronchitis</li><li><input type="checkbox"/> Chronic cough</li><li><input type="checkbox"/> Emphysema</li><li><input type="checkbox"/> Shortness of breath</li></ul> <p><b>Infections</b></p> <ul style="list-style-type: none"><li><input type="checkbox"/> Hepatitis</li><li><input type="checkbox"/> Herpes</li><li><input type="checkbox"/> HIV</li><li><input type="checkbox"/> TB</li></ul> <p><b>Head and Neck</b></p> <ul style="list-style-type: none"><li><input type="checkbox"/> Hearing problems</li><li><input type="checkbox"/> History of headaches</li><li><input type="checkbox"/> History of migraine</li><li><input type="checkbox"/> Vision problems</li></ul>
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<p><b>Other conditions</b></p> <ul style="list-style-type: none"><li><input type="checkbox"/> Allergies or hypersensitivity to: _____</li><li><input type="checkbox"/> Anemia (Low iron)</li><li><input type="checkbox"/> Cancer</li><li><input type="checkbox"/> Diabetes</li><li><input type="checkbox"/> Digestive conditions</li><li><input type="checkbox"/> Epilepsy</li><li><input type="checkbox"/> Fibromyalgia</li><li><input type="checkbox"/> Hemophilia</li><li><input type="checkbox"/> Lupus</li><li><input type="checkbox"/> Mental health issues: _____</li><li><input type="checkbox"/> Multiple sclerosis</li><li><input type="checkbox"/> Osteoarthritis</li><li><input type="checkbox"/> Osteoporosis</li><li><input type="checkbox"/> Rheumatoid arthritis</li><li><input type="checkbox"/> Skin conditions: _____</li><li><input type="checkbox"/> Thyroid imbalance: hyper or hypo</li><li><input type="checkbox"/> Tingling or loss of sensation in: _____</li><li><input type="checkbox"/> Tinnitus</li><li><input type="checkbox"/> Anything else? (Please specify): _____</li></ul> <p><b>Women</b></p> <ul style="list-style-type: none"><li><input type="checkbox"/> If pregnant, when due: _____</li></ul>
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Is there a family history of any of the above conditions?  Yes  No

Briefly, which ones? \_\_\_\_\_

Do you have any internal pins, wires, artificial joints or special equipment?  Yes  No

If yes, please explain: \_\_\_\_\_

Is there anything else we should know about your health before we begin our treatment?  Yes  No

If yes, please explain: \_\_\_\_\_

**CANCELLATION POLICY: please call us at least 24 hours before your appointment start time to change or cancel your appointment, or you will be charged the full fee for the appointment.**

Date of initial health history: _____
Update 1 _____
Update 2 _____
Update 3 _____
Update 4 _____