

Sage Wellness Health History Form

The information request below will assist us in treating you safely. Feel free to ask any questions about the information being requested. Please note that all information provided will be kept confidentially unless allowed or required by law. Your written permission will be required to release any information.

Name: _____ Phone #: _____

Address: _____ E-mail address: _____

Occupation: _____ Date of Birth: _____

Have you received massage therapy before? Yes__ No__

Did a Health care practitioner refer you for massage therapy? Yes__ No__

If yes, please provide their name and address: _____

Please indicate below the conditions you are experiencing or have experienced:

<p><u>Cardiovascular</u></p> <ul style="list-style-type: none"> <input type="checkbox"/> High blood pressure <input type="checkbox"/> Low blood pressure <input type="checkbox"/> Chronic congestive heart failure <input type="checkbox"/> Heart attack <input type="checkbox"/> Phlebitis/varicose veins <input type="checkbox"/> Stroke/CVA <input type="checkbox"/> Pacemaker or similar device <input type="checkbox"/> Heart disease <p>Is there a family history of any of the above? Yes__ No__</p> <p><u>Respiratory</u></p> <ul style="list-style-type: none"> <input type="checkbox"/> Chronic cough <input type="checkbox"/> Shortness of breath <input type="checkbox"/> Bronchitis <input type="checkbox"/> Asthma <input type="checkbox"/> Emphysema <p>Is there a family history of any of the above? Yes__ No__</p>	<p><u>Infections</u></p> <ul style="list-style-type: none"> <input type="checkbox"/> Hepatitis <input type="checkbox"/> Skin conditions <input type="checkbox"/> TB <input type="checkbox"/> HIV <input type="checkbox"/> Herpes <p><u>Other Conditions</u></p> <ul style="list-style-type: none"> <input type="checkbox"/> Loss of sensation, Where? _____ <input type="checkbox"/> Diabetes, onset: _____ <input type="checkbox"/> Allergies/hypersensitivity, to what? _____ <input type="checkbox"/> _____ <input type="checkbox"/> Type of reaction: _____ <input type="checkbox"/> Epilepsy <input type="checkbox"/> Cancer, where? _____ <input type="checkbox"/> Skin conditions, what? _____ <input type="checkbox"/> _____ <input type="checkbox"/> Arthritis <p>Is there a family history of arthritis? Yes__ No__</p>	<p><u>Head/Neck</u></p> <ul style="list-style-type: none"> <input type="checkbox"/> History of headaches <input type="checkbox"/> History of migraines <input type="checkbox"/> Vision problems <input type="checkbox"/> Vision loss <input type="checkbox"/> Ear problems <input type="checkbox"/> Hearing loss <input type="checkbox"/> Jaw problems/pain <p>Pregnant, due: _____</p> <p>Gynaecological conditions, What? _____</p> <p>How is your general health? _____</p> <p>Primary Care Physician: _____</p> <p>Address: _____</p> <p>_____</p> <p>_____</p> <p>_____</p>
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<p>Current Medications: _____</p> <p>Condition Treated: _____</p> <p>Are you currently receiving treatment from another health care professional? Yes__ No__</p> <p>If yes, for what? _____</p> <p>Surgery – date: _____</p> <p>Nature: _____</p> <p>Injury – date: _____</p> <p>Nature: _____</p>	<p>Do you have any other medical conditions (eg digestive conditions, haemophilia, osteoporosis, mental illness) Yes__ No__</p> <p>What? _____</p> <p>Do you have any internal pins, wires, artificial joints, or special equipment? Yes__ No__</p> <p>What? _____</p> <p>Where? _____</p> <p>What is the reason you are seeking massage therapy? Please include the location of any tissue or joint discomfort.</p> <p>_____</p> <p>_____</p>
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It is ok for Sage Wellness to contact me at the contact information I have provided above.

<p>Date of Initial Health History: _____</p> <p>Update 1: _____</p> <p>Update 2: _____</p> <p>Update 3: _____</p> <p>Update 4: _____</p>
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