WorkingWell
Bringing Wellness To Work

CONFIDENTIAL CLIENT HEALTH HISTORY FORM

For your information:
An accurate health history is required to ensure that it is safe for you to receive a massage treatment. If your health status changes in the future, please let me know. 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.

Name: ____ **Date:** __________________________

Address: ____ **Tel: res** _________________________

____ **Tel: bus** _________________________

Date of Birth ____________________ **Occupation**____

Primary Concern/Complaint? __________________________________

HEALTH HISTORY - Please indicate conditions you are experiencing, or have experienced in the past:

GENERAL	RESPIRATORY	CARDIOVASCULAR	SKIN
• headaches/migraines • dizziness • fatigue • fibromyalgia • chronic fatigue syndrome • seasonal allergies	• chronic cough • bronchitis • emphysema • asthma	• high/ low blood pressure • phlebitis • heart / disease / attack • stroke / CVA • pacemaker • chronic congestive heart failure	• sensitive • bruise easily • eczema • varicose veins • psoriasis
HEAD/NECK	**WOMEN**	**COMMUNICABLE DISEASES**	**OTHER**
• vision problems • ear problems • vertigo • sinus	• menstrual problems • menopausal problems • pregnant (due_____________) **MEN** • prostate cancer • testicular cancer	• TB • Hepatitis • HIV • HSV • Other: _______________	• cancer • arthritis OA • arthritis RA • epilepsy • haemophilia • diabetes – onset___________

SOFT TISSUE/JOINT DISCOMFORT

- neck ____
- shoulders ____
- upper back _______________________________________
- lower back _______________________________________
- arms ____
- legs____
- other ____

Special Note of any Pins, Wires, artificial joints:
____

Current Medications ______________________________________

Physician Name/# ____
Address____

Surgery _______________________ **Date**_____________

Injury _________________________ **Date** _____________

Other Healthcare Treatment _________________________

I understand and agree that the following information on this form is accurate, current and is confidential.
I consent to massage therapy treatment and agree to discuss with the therapist the nature and purpose of therapeutic massage. I understand and am informed that, as in all healthcare, there are some risks to treatment which, if applicable, will be discussed before the treatment.

______________________________ ______________________________
Signature **Date**