Mary-Ellen Rozon
Registered Massage Therapist

Health History Form

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

Name: _____ Date: _____
Address: _____ Phone (Home): _____
City: _____ Postal Code: _____ (Work): _____
Occupation: _____ Birth Date: _____
E-mail: _____
Have you received massage therapy before? _____
Did a health care practitioner refer you for massage therapy? _____
If yes, please provide their name and address. _____

Please indicate conditions you are experiencing or have experienced:

Cardiovascular

- ❑ High Blood Pressure
- ❑ Low Blood Pressure
- ❑ Chronic Congestive Heart Failure
- ❑ Heart Attack
- ❑ Phlebitis/Varicose Veins
- ❑ Stroke/CVA
- ❑ Pacemaker or Similar Device
- ❑ Heart Disease

Is there a family history of any of the above?
- ❑ Yes
- ❑ No

Respiratory

- ❑ Chronic Cough
- ❑ Shortness of Breath
- ❑ Bronchitis
- ❑ Asthma
- ❑ Emphysema

Is there a family history of any of the above?
- ❑ Yes
- ❑ No

Infections

- ❑ Hepatitis
- ❑ Skin Conditions
- ❑ TB
- ❑ HIV
- ❑ Herpes

Other Conditions

- ❑ Loss of Sensation, Where? _____
- ❑ Diabetes, Onset: _____
- ❑ Allergies/Hypersensitivity to What? _____ _____ Type of Reaction: _____
- ❑ Epilepsy
- ❑ Cancer, Where? _____ _____
- ❑ Skin Conditions, What? _____ _____
- ❑ Arthritis

Is there a family history of arthritis?
- ❑ Yes
- ❑ No

Head/Neck

- ❑ History of Headaches
- ❑ History of Migraines
- ❑ Vision Problems
- ❑ Vision Loss
- ❑ Ear Problems
- ❑ Hearing Loss

Women

- ❑ Pregnant, due: _____ _____
- ❑ Gynecological conditions, What?_____ _____

Overall, how is your general health?
_____

Primary Care Physician:
_____
Address:
_____
_____
_____

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Current Medications:
_____
_____
_____

Are your currently receiving treatments from another health care professional?
_____
If yes, for what? _____
_____

Any previous injuries? (car, sports, falls, etc.) _____ Description and approx. date _____
_____
_____

Any surgeries? _____ Description and approx. date _____
_____

Do you have any other medical conditions? (e.g. digestive conditions, hemophilia, osteoporosis, mental illness)
- ❑ Yes
- ❑ No

What? _____
_____

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

What? _____
Where? _____

What is the reason you are seeking massage therapy? Please include the location of any tissue or joint discomfort.
_____

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Date of Initial Health History: _____
Update 1 _____
Update 2 _____
Update 3 _____
Update 4