ESPOSITO MASSAGE
Discover Your Path To Wellness

Health History Form

For your information:
An accurate health history is important to ensure that it is safe for you to receive a massage therapy treatment. If your health status changes in the future, please inform the therapist. All information gathered for this treatment is confidential except as required or allowed by law or except to facilitate assessment or treatment. You will be asked to provide written authorization for release of any information.

First Name: _____ Last Name: _____

Address: _____ Telephone (H): _____

_____ Postal Code: _____ (W): _____

E-mail: _____ (C): _____

ICBC Adjuster Contact: _____ ICBC Claim No.: _____

Date of Accident: _____

Date of Birth: _____ Occupation: _____ Tasks Included:_____

Primary Care Physician: _____ Telephone: _____

Address: _____

Emergency Contact Person: _____ Telephone: _____

Present Involvement in Other Health Care (please specify):_____

Referred By: _____ Address: _____

Primary Complaint: _____

What do you expect from your massage treatment: _____

Do you have any allergies (nuts, oils, etc.): _____

Medications: _____ **Conditions it treats:** _____

_____ _____

_____ _____

Surgery: _____ **Date:** _____

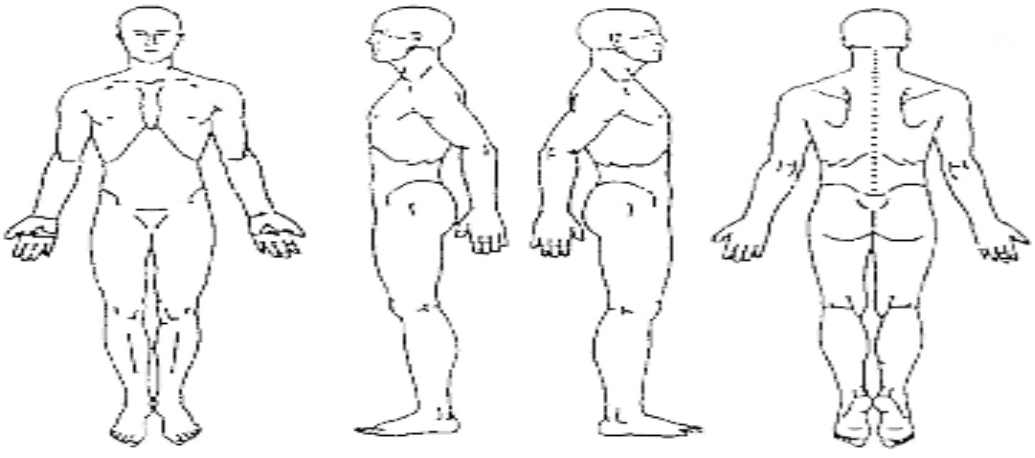
_____ **Date:** _____

Injury: _____ **Date:** _____

_____ **Date:** _____

Please indicate the following on the chart below:

O – Burning **X** – Pain/discomfort # - Numbness/Tingling □ – Muscle stiffness



Please indicate if conditions are past or current:

HEAD / NECK

P C
- ☐ ☐ Headaches
- ☐ ☐ Vision Problems
- ☐ ☐ Contact Lenses
- ☐ ☐ Ear Aches
- ☐ ☐ Hearing Loss
- ☐ ☐ Sinus Infections
- ☐ ☐ Family History of _____

RESPIRATORY

P C
- ☐ ☐ Chronic Cough
- ☐ ☐ Shortness of Breath
- ☐ ☐ Bronchitis
- ☐ ☐ Asthma
- ☐ ☐ Emphysema
- ☐ ☐ Family History of _____
- ☐ ☐ Other: _____

CARDIOVASCULAR

P C
- ☐ ☐ High Blood Pressure
- ☐ ☐ Low Blood Pressure
- ☐ ☐ CCHF
- ☐ ☐ Heart Attack
- ☐ ☐ Angina
- ☐ ☐ Heart Disease
- ☐ ☐ Stroke
- ☐ ☐ Phlebitis
- ☐ ☐ Poor Circulation
- ☐ ☐ Varicose Veins
- ☐ ☐ Family History of _____

SKIN

P C
- ☐ ☐ Eczema
- ☐ ☐ Bruise Easily
- ☐ ☐ Other (please specify): _____

DIGESTIVE / URO-GENTIAL

P C
- ☐ ☐ Difficult Digestion
- ☐ ☐ Constipation
- ☐ ☐ Kidney Stones
- ☐ ☐ Family History of _____
- ☐ ☐ Other: _____

OTHER CONDITIONS

P C
- ☐ ☐ Loss of Sensation
- ☐ ☐ Numbness
- ☐ ☐ Tingling
- ☐ ☐ Frequent Colds
- ☐ ☐ Insomnia
- ☐ ☐ Arthritis
- ☐ ☐ Cancer Type: _____
- ☐ ☐ Epilepsy
- ☐ ☐ Fibromyalgia
- ☐ ☐ Family History of _____

INFECTIOUS CONDITIONS

- ☐ TB
- ☐ AIDS/HIV
- ☐ Hepatitis Type: _____

FEMALE

- ☐ Menstrual Problems
  - ☐ Painful
  - ☐ Heavy
  - ☐ Irregular
- ☐ Pregnant, due date: _____
- ☐ Children: number _____
- ☐ Menopause
- ☐ Post-Menopause

OF SPECIAL NOTE

- ☐ Pins
- ☐ Wires
- ☐ Artificial Joints/Limbs

MUSCLE AND JOINT

P C
- ☐ ☐ Neck
- ☐ ☐ Low Back
- ☐ ☐ Upper Back
- ☐ ☐ Shoulders
- ☐ ☐ Arms
- ☐ ☐ Legs
- ☐ ☐ Knees
- ☐ ☐ Other: _____

HABITS

P C
- ☐ ☐ Coffee # of cups/day:_____
- ☐ ☐ Tea #. of cups/day:_____
- ☐ ☐ Alcohol #. of beverages/week:___
- ☐ ☐ Computer work # of hours/day:____
- ☐ ☐ Exercise # of times/week:____
- ☐ ☐ Water # of cups/day:_____

I, _____, declare that all of the above information to be true. *I understand that I have 24 hours to cancel an appointment or full fees apply*. I understand that massage therapy is for the purposes of stress reduction, relief from muscular tension and spasm, general relaxation, improvement of blood circulation and lymph movement, increasing mobility and range of motion of joints, and relief of acute and chronic pain. I am aware of the benefits and risks, and I give my consent for a massage treatment. I understand that there is no implied or stated guarantee of success or effectiveness for massage sessions. I understand that Massage Therapists do not diagnose illness, disease or any other physical or mental disorder, nor do they prescribe medical treatment or pharmaceuticals. I understand that massage therapy is not a substitute for medical examination or diagnosis and it is recommended that I see a physician for any physical ailment I have. I understand that any information provided by the therapists is for educational purposes only, and is not diagnostic in nature. I understand that if at any time I am uncomfortable with the massage or any technique being used, I can ask the therapist to stop, change techniques, or end the massage. I am always in complete control of the treatment.

Signature: _____ Date: _____