Laberge Massage Therapy
Trusted. Focused. Caring.

CONFIDENTIAL HEALTH HISTORY FORM
(3 Pages)

Name: _____ Date: _____

Date of Birth: _____

Address: _____ City/State/Zip: _____

Phone: (H): _____ (W): _____ (C): _____

Occupation: _____ Email: _____

Emergency Contact Name: _____ Phone: _____

Date of last massage: _____

What type of pressure do you prefer during your massage? __ Light __ Moderate __ Deep

List stress reduction and exercise activities including frequency: _____

_____

MEDICAL HISTORY (Include year and treatment received):

Are you currently seeing a medical practitioner? _____ If yes, please explain: _____

_____

List current medications including: aspirin, ibuprofen, herbs, supplements, etc.: _____

_____

_____

Allergies:_____

Accidents/Injuries/Illnesses/Surgeries: _____

_____

_____

Contacts? _____ Dentures? _____ Transdermal patches (nicotine)? _____ IV Port? _____

Please place a check mark in the past and/or current box next to any items that apply to your health history.

Musculoskeletal:

Past	Current	Condition	Past	Current	Condition	Past	Current	Condition
		Lupus			Head Injury			Jaw Pain
		Bone/Join Disease			Spasms/Cramps			Neck Pain
		Bursitis			Broken/Fractures bones			Shoulder Pain
		Tendonitis			Sprains/Strains			Arm Pain
		Rheumatoid Arthritis			Other			Low Back Pain
		Osteoarthritis						Hip Pain

Circulatory:

Past	Current	Condition	Past	Current	Condition	Past	Current	Condition
		Heart Condition			High Blood Press.			Lymphedema
		Blood Clots			Low Blood Press.			Varicose Veins

Skin:

Past	Current	Condition	Past	Current	Condition	Past	Current	Condition
		Allergies			Rashes			Athlete's Foot
		Warts						

Nervous System:

Past	Current	Condition	Past	Current	Condition	Past	Current	Condition
		Numbness/Tingling			Herpes/Shingles			Sleep Disorders
		Chronic Pain			Fatigue			Other:

Digestive/Urinary System:

Past	Current	Condition	Past	Current	Condition	Past	Current	Condition
		Constipation			Diverticulitis			Kidney/Bladder
		Gas/Bloating			Irritable Bowel Syndrome			

Respiratory System:

Past	Current	Condition	Past	Current	Condition	Past	Current	Condition
		Asthma			Breathing Difficulty			Allergies
		Sinus Problems			Other:			

Reproductive & PMS:

Past	Current	Condition	Past	Current	Condition	Past	Current	Condition
		Bloating			Mood Swings			Painful Periods
		Cramps/Pain			Breast Tenderness			Irregular Periods
		Pre-menopausal or Menopausal Symptoms			Pregnancy –If current, # of weeks?			Absent Periods

It is my choice to receive massage therapy; I realize that the massage is being given for the well-being of my body and mind. This includes stress reduction, relief from muscular tension, spasms and or pain. I agree to openly communicate with my practitioner during my session (e.g., comfort on table, pressure, safety, etc.).

I understand that massage therapists do not diagnose illness, disease or any physical or mental disorder; nor do they prescribe medical treatment, pharmaceuticals or perform spinal thrust manipulations. I acknowledge massage is not a substitute for medical examination or diagnosis and it is recommended that I see a primary health care provider for that service. I stated all medical conditions I am aware of and will update my health statues with my therapist.

I agree to cancel my scheduled appoint at least 24 hours in advance. I understand that less than 24-hour notice will result in billing for my dedicated appointment time.

Signature: _____ Date: _____