



Finding Flow Confidential 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 below will be kept confidential unless allowed or required by law. Your written permission will be required to release any information.

Name: _____ Phone #: (H) _____ (W) _____

Address: _____ Email: _____

Occupation: _____ Date of Birth: / /

Have you received massage before? Yes No Emergency Contact: _____ (P#) _____

Did a health care practitioner refer you for massage therapy? Yes No If Yes, who? _____

Please indicate conditions you are experiencing or have experienced:

<p>General:</p> <input type="checkbox"/> Headaches Type: _____ <input type="checkbox"/> Vision Problems / Vision Loss <input type="checkbox"/> Ear Problems/ Hearing Loss <input type="checkbox"/> Sinus Problems <input type="checkbox"/> Allergies / Hypersensitivity to what? _____ Type of reaction: _____ <input type="checkbox"/> Chronic Pain _____ <input type="checkbox"/> Chronic Fatigue <input type="checkbox"/> Dizziness <input type="checkbox"/> Premenstrual Syndrome (PMS) <input type="checkbox"/> Menopause <input type="checkbox"/> Pregnancy Due Date: _____	<p>Cardiovascular:</p> <input type="checkbox"/> High Blood Pressure - If yes, are you taking medication? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Low Blood Pressure - If yes, are you taking medication? <input type="checkbox"/> Yes <input type="checkbox"/> No <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 _____ Is there a family history of any of the above? <input type="checkbox"/> Yes <input type="checkbox"/> No	<p>Muscle & Joint:</p> <input type="checkbox"/> Stiffness <input type="checkbox"/> Pain - Where? _____ <input type="checkbox"/> Limited Movement <input type="checkbox"/> Pins & Needles <input type="checkbox"/> Rheumatoid Arthritis (RA) Date Diagnosed _____ <input type="checkbox"/> Osteoarthritis (OA) Date Diagnosed _____ <input type="checkbox"/> Other Joint Pathology _____ Is there a family history of arthritis? <input type="checkbox"/> Yes <input type="checkbox"/> No
<p>Respiratory:</p> <input type="checkbox"/> Chronic Cough <input type="checkbox"/> Shortness of Breath <input type="checkbox"/> Asthma <input type="checkbox"/> Bronchitis <input type="checkbox"/> Emphysema <input type="checkbox"/> Smoke #/day _____ Is there a family history of any of the above? <input type="checkbox"/> Yes <input type="checkbox"/> No	<p>Infections:</p> <input type="checkbox"/> Hepatitis <input type="checkbox"/> Skin Condition _____ <input type="checkbox"/> Tuberculosis <input type="checkbox"/> HIV / AIDS <input type="checkbox"/> Herpes <p>Digestive / Uro-Genital:</p> <input type="checkbox"/> Hernia <input type="checkbox"/> Constipation <input type="checkbox"/> Liver/Gallbladder Problems <input type="checkbox"/> Kidney/Bladder Problems <input type="checkbox"/> Digestive Problems (ie. IBS, IBD) <input type="checkbox"/> Other _____	<p>Other Conditions:</p> <input type="checkbox"/> Loss of Sensation <input type="checkbox"/> Diabetes Onset: _____ <input type="checkbox"/> Epilepsy <input type="checkbox"/> Cancer Type/Where: _____ Overall, how is your general health ? _____ Primary Care Physician: _____ Address: _____

Current Medications: _____

Condition it Treats: _____

Are you currently receiving treatment from **another health care professional**? Yes No
If Yes, for what? _____

Surgery/Injuries - Date: _____
Nature: _____

Do you have any other **medical conditions**? (e.g. haemophilia, osteoporosis, mental illness) Yes No
Condition: _____

Do you have any **internal pins, wires, artificial joints or special equipment**? Yes No
What? _____
Where? _____

What is your **primary reason** for seeking massage therapy?

I understand that all the information on this form will be kept confidential and I acknowledge that it is accurate and complete. I understand that if my health changes it is my responsibility to update my file.

Date: _____ Signature: _____

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