Relax Massage: Health History Form

Name: _____ D.O.B.: _____
Address: _____
Mob. Phone. _____ Email:_____
Name & number in case of emergency: _____
Occupation: _____
How did you hear about us? _____

Please tick (x) all the conditions that apply now and put a **P** for past conditions:

□ Heart, Circulatory Problems	□ Cancer/Tumours	□ Vision Problems
□ High/Low Blood Pressure	□ Asthma	□ Hearing Problems
□ Varicose Veins	□ Difficulty Breathing	□ Fatigue
□ Blood Clots	□ Hernias	□ Depression
□ Phlebitis	□ Digestive Problems	□ Seizures
□ Infectious Disease	□ Osteoarthritis/Rheumatoid	□ Stroke
□ Rash, Tinea	□ Numbness/Tingling	□ Skin Disorders
□ Allergies	□ Muscle Injury/Pain	□ Pregnancy
□ Diabetes	□ Bone Injury/Pain	□ Headaches
□ Motor Vehicle Accident	□ Joint Injury/Pain	□ Migraines
□ Accident/Trauma	□ Chronic Pain	□ Memory Loss/Confusion
□ Broken Bones	□ Disc Problems	□ Prosthesis

Please, provide further details of any conditions you have indicated: _____
_____

Other medical conditions not listed (past/present): _____
_____

Are you currently on any medications? Yes □ No □ Details: _____
_____

Recent surgeries: None □ Details: _____

Name of your primary health care provider (doctor): _____

I give permission for my Remedial Therapist to consult with my doctor regarding my health and treatment if required Yes □ No □

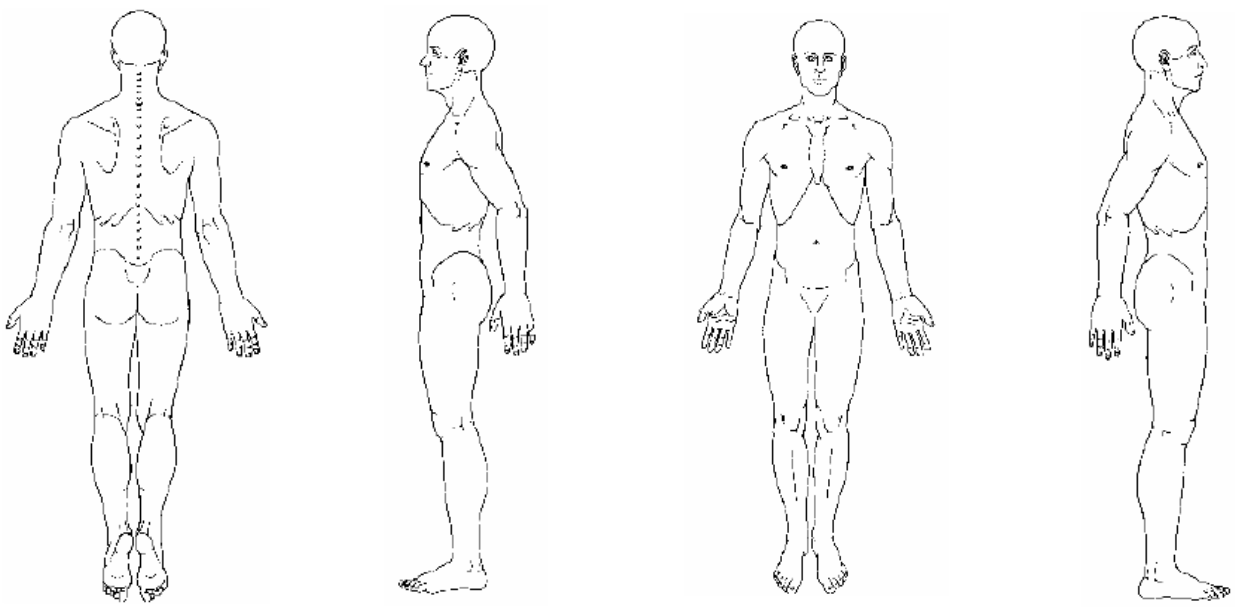
Have you had a Remedial Massage before? Yes □ No □

What are your current complaints of injuries? _____
_____

Which of the following best describe what you are experiencing?

Pain	□	Mild	□	Getting worse	□	Increase with activity	□
Ache	□	Moderate	□	Staying the same	□	Reduces with activity	□
Tension	□	Disabling	□	Getting better	□	No change	□
Discomfort	□	Constant	□				
Imbalance	□	Intermittent	□				

On the diagram below identify where your current symptoms are by circling the area and marking it with a: **P** = Pain **S** = Muscle stiffness **JT** = Joint pain **N** = Numbness & tingling:



Notes: _____

_____

_____

Consent is required to massage each part of the body. Please, indicate which areas you would like to be included (**For relaxation massage clients only**):

□ Back □ Buttocks □ Legs □ Feet □ Arms □ Stomach □ Chest □ Face □ Head □ Neck

If you would like us to email you details of our upcoming promotions, please tick: Yes □ No □

Important: The remedial assessment and treatment procedures of 'Remedial Massage & Musculoskeletal Therapy' have been fully explained to me. I give full consent for the therapist to observe, palpate and treat each part of the body as required. It may be necessary to discuss my condition and treatment with my doctor. I have disclosed all relevant medical history, medications, and current symptoms prior to treatment.

Signature: _____ Date: _____