Kind Cactus Massage

Health History Form

This information is confidential and will not be released without your written consent unless required by law.
It will be used to provide you with safe, effective treatment.

Name: ____ Date of Birth: _________ /_________ /_________
day month year

Address: ____

____ Postal Code: _______________________

Cell Phone: ________________________________ Email: ____

Other Phone: ________________________________ Occupation: _______________________________________

Doctor: _____________________________________ Contact: ____

Did someone refer you for massage? ☐ Yes ☐ No If yes, who: _____________________________________

Do you exercise regularly? ☐ Yes ☐ No If yes, describe: ____

____

Have you received massage therapy before? ____

Are you currently receiving treatment from another health care professional? ___________________________

What is your main reason for seeking massage? ____

Other concerns: ____

Please check all conditions that apply to you:

Respiratory

- ☐ Chronic cough
- ☐ Shortness of breath
- ☐ Bronchitis
- ☐ Asthma
- ☐ Emphysema
- ☐ Smoker

Infections

- ☐ Hepatitis
- ☐ Tuberculosis
- ☐ HIV
- ☐ Herpes/cold sores
- ☐ Other______________

Reproductive

- ☐ Prostate issues:
  ____
- ☐ Menstrual difficulties
- ☐ Gynecological issues:
  ____
- ☐ Pregnant ________ months
  Due date: _______________
- ☐ Menopause since _________

Cardiovascular

- ☐ High/low blood pressure
  Last BP reading _____________
- ☐ Poor circulation
- ☐ Heart disease
- ☐ Angina
- ☐ Atherosclerosis
- ☐ Fainting
- ☐ Stroke/CVA
- ☐ Phlebitis/varicose veins
- ☐ Hemophilia
- ☐ Heart attack
  Date: ________________
- ☐ Chronic Congestive Heart Failure

Skin

- ☐ Sensitive skin
- ☐ Psoriasis/eczema
  Where? _______________
- ☐ Easily bruise
- ☐ Infectious skin conditions:
  What? ________________

Other Conditions

- ☐ Seizures/epilepsy
- ☐ Diabetes, type: __________
- ☐ Constipation
- ☐ Hernia
- ☐ Cancer, type: ____________
- ☐ Headaches
- ☐ Migraines
- ☐ Vision problems/loss
- ☐ Hearing problems/loss
- ☐ Dizziness
- ☐ Allergies, to what: __________
  Type of reaction: ___________
- ☐ Arthritis, type: _____________
- ☐ Stiffness/limited movement
  Where? _________________
- ☐ Tingling, electric pain
  Where? ______________
- ☐ Loss of sensation/numbness
  Where? _________________

Overall, how is your general health? ______________________

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Please list any other health conditions that apply to you, e.g., fibromyalgia, neuromuscular disorders, degenerative disc disease, osteoporosis, etc. ____

Do you have any other comments about your health? ____

Do you have any internal pins, wires, artificial joints, pacemakers, or special equipment? Please list:

____

Please list all of your medications:

____ to treat ____

____ to treat ____

____ to treat ____

____ to treat ____

Please list all surgeries and/or injuries:

____ Date: __________________________

____ Date: __________________________

____ Date: __________________________

____ Date: __________________________

____ ____________________________________

Signature Date

Updated:

____ ____________________________________

Signature Date

____ ____________________________________

Signature Date

____ ____________________________________

Signature Date