Masahe Studio
Patient History Form

Please take a moment to fill out this confidential health history form. This will ensure that you receive proper treatment and that it is safe for you to do so. Thank you.

Date:_____

Name (please print):_____

Address:_____

City:_____ Postal Code:_____

Phone: (Home)_____ Business:_____

Cell:_____ Email: _____

Date of Birth: _____/_____/_____ Sex: M F

Occupation:_____ Employer:_____

Regular hobbies/sports/activities:_____

_____

Physician name/address/phone:_____

_____

Have you recently been in a motor vehicle accident / work related injury to which you will be making claim? YES NO

Allergies?_____

What is your primary concern?_____

_____

Can you describe it? DULL SHARP SHOOTING ACHY NUMB TINGLING STIFF

Does it radiate anywhere?_____

Does anything aggravate your symptoms?_____

Does anything relieve your symptoms?_____

When did your symptoms begin?_____

Are you presently taking any medications? Please list them: _____

Have you seen any other health care practitioner(s) concerning this complaint?

Medical Dr.
Chiropractor
Physiotherapist
Massage Therapist
Other _____

Have they provided results?_____

Surgery/injuries/hospitalization: (date, past & current symptoms)_____

_____

Have you been treated for any of the following in the last five years?

_____ Hyper/hypotension
_____ Heart Condition
_____ Respiratory Condition
_____ Neurological Disorder
_____ Headaches
_____ Temporal Mandibular Joint (jaw)
_____ Whiplash
_____ Fainting/Dizziness
_____ Circulatory Condition
_____ Digestive Problems
_____ Menopause
_____ Sinuses
_____ Hyper/Hypothyroidism
_____ Cancer, specify_____
_____ Skin Conditions, specify_____
_____ H.I.V/Hepatitis
_____ Allergies, specify_____
_____ Depression/Anxiety
_____ Upper Back Pain
_____ Lower Back Pain
_____ Joint Pain
_____ Abdominal Pain
_____ Diabetes
_____ Osteoporosis
_____ Arthritis, specify_____

Who may I thank for this referral?_____

I understand and agree that the information contained herein is true to the best of my knowledge and all information will be kept confidential.

Due to the contact required for massage therapy treatments, we require that if you are suffering from a contagious or communicable disease you must inform the therapist and your family physician.

Signature:_____

Date:_____

Therapist:_____