Office Use Only
Initial ____________ BP__________
Update ____________ BP __________
Update ____________ BP __________
Update ____________ BP __________

Above and Beyond Massage Therapy Clinic
Health History

Accurate information in this health history will ensure that it is safe to receive a massage treatment. If at any time your information changes, please let us know. All information in this health history is confidential, except when required by law. You will be asked to provide written authorization to release any of this information.

Name:____ Phone: ________________________
Address:____ Work: ________________________
City:____________________ Postal Code:____________________ Cell:________________________
D.O.B. (mm/dd/yy):_____/_____/_____ Email: ____
Occupation:________________________________ Have you received massage therapy in the past? ☐ Yes ☐ No
What is your chief complaint?: ____
How did you hear about the clinic?: ____
Primary Physician:_________________________________ Phone: ____________________________
Address: ____

Please check the conditions that you are currently having or have experienced in the past.

Head/Neck:
- ☐ Headaches
- ☐ Migraines
- ☐ Vision Problems
- ☐ Hearing Problems

Respiratory:
- ☐ Shortness of Breath
- ☐ Chronic Cough
- ☐ Bronchitis
- ☐ Asthma
- ☐ Emphysema

Cardiovascular:
- ☐ High blood pressure
- ☐ Low blood pressure
- ☐ Chronic congestive heart failure
- ☐ Heart attack
- ☐ Phlebitis / varicose veins
- ☐ Stroke / CVA
- ☐ Heart Disease
- ☐ Pacemaker

Surgery:
Type:__________________________
Date:__________________________
Injury:_________________________
Type:__________________________
Date:__________________________
Current Symptoms: _______________
Presence of internal pins, wires or artificial joints/limbs? ☐ Yes ☐ No If yes, where?
____

Skin:
- ☐ Skin Conditions
  *Types:*________________________
- ☐ Bruise Easily
- ☐ Irritations?

Other Conditions:
- ☐ Stress
- ☐ Anxiety
- ☐ Depression
- ☐ Difficult Digestion
- ☐ Constipation
- ☐ Diabetes: *Onset*____
- ☐ Epilepsy
- ☐ Allergies
- ☐ Cancer: _________
- ☐ Loss of sensation, where?
  ____
- ☐ Arthritis *MD Diagnosed? ☐ Yes ☐ No*
  Area affected: ________________
  Is there a family history of arthritis?
  ☐ Yes ☐ No

Infections:
- ☐ Athlete's foot
- ☐ Hepatitis
- ☐ Plantar Warts
- ☐ HIV, AIDS

Other diagnosed diseases not listed, specify:
____

Women:
- ☐ Painful Menstruation
- ☐ Gynecological Surgery
- ☐ Pregnant: *Due Date*: ______________
- ☐ Menopausal problems

Muscle/Joint Pain:
- ☐ Neck
- ☐ Low Back
- ☐ Upper Back
- ☐ Shoulders
- ☐ Legs: Right / Left
- ☐ Hip: Right / Left
- ☐ Knee: Right / Left
- ☐ Arms: Right / Left
- ☐ Ankles: Right / Left
- ☐ Feet: Right / Left
- ☐ Jaw Pain / TMJ
- ☐ Fibromyalgia
- ☐ Scoliosis

Other_____________________________

Current Medications:
Name _______________ For: _________
Name _______________ For: _________
Over the counter: __________________
Herbal: ___________________________

Other Healthcare:
- ☐ Chiropractic
- ☐ Physiotherapy
- ☐ Massage Therapy
- ☐ Regular Exercise

Overall, how is your general health?
____

Please note:
A 24-hour cancellation is required, or a service charge may apply.

➔ **Consent to Treatment**____ **Date:**________________