HEALTH HISTORY

LINDSAY SWITZER, RMT

The following information you provide will assist me in treating you safely and effectively. Please feel free to ask any questions or voice any concerns you may have regarding the questions listed below. Please note that all information you provide will be kept strictly confidential, unless allowed by yourself (the client) or required by law. Your written permission will be required to release any personal information.

Name: _____ Date: _____
Address: _____ Phone #: _____
Occupation: _____ Date of Birth: _____
E-mail: _____
Primary Care Physician (name/addr/phone): _____

Have you ever received Massage Therapy before? ☐ NO ☐ YES -- When?: _____
Were you referred by a healthcare practitioner? ☐ NO ☐ YES -- Contact info:_____

Currently/Previously
☐ ☐

Cardiovascular
- ☐ ☐ High Blood Pressure
- ☐ ☐ Low Blood Pressure
- ☐ ☐ Congestive Heart Failure
- ☐ ☐ Cardiac Event (i.e. Heart Attack)
  When: _____
- ☐ ☐ CVA (i.e. Stroke)
  When: _____
- ☐ ☐ Pacemaker
  Date: _____
- ☐ ☐ Inflammatory Veins/Arteries
- ☐ ☐ Blood Clot / DVT
  Location: _____

Respiratory
- ☐ ☐ Asthma
- ☐ ☐ Bronchitis
- ☐ ☐ Emphysema
- ☐ ☐ Shortness of Breath
- ☐ ☐ COPD
- ☐ ☐ Cystic Fibrosis
- ☐ ☐ Severe Allergies affecting breathing:_____
- ☐ ☐ Supplemental Oxygen tank

Infections
- ☐ ☐ Hepatitis
- ☐ ☐ Tuberculosis
- ☐ ☐ HIV
- ☐ ☐ Herpes
- ☐ ☐ Skin Condition:_____
- ☐ ☐ Chronic sinus infections

Orthopedic
- ☐ ☐ Fracture/Dislocation
  Loc/Date: _____
- ☐ ☐ Osteoporosis
- ☐ ☐ Surgical Hardware
  Loc/Date: _____

Systemic Conditions
- ☐ ☐ Lupus
- ☐ ☐ Fibromyalgia
- ☐ ☐ Cancer
- ☐ ☐ Diabetes
- ☐ ☐ Epilepsy
- ☐ ☐ Osteoarthritis
- ☐ ☐ Rheumatoid Arthritis
- ☐ ☐ Bleeding Disorder (describe)

Head/Neck
- ☐ ☐ Headaches
- ☐ ☐ Migraines
- ☐ ☐ Whiplash
  Date: _____
- ☐ ☐ Vision problems/loss
- ☐ ☐ Hearing problems/loss
- ☐ ☐ Chronic ear infections
- ☐ ☐ Nausea
- ☐ ☐ Vertigo/Dizziness
- ☐ ☐ Claustrophobia

Women
- ☐ ☐ Pregnancy
  Due: _____
- ☐ ☐ Surgical removal of: _____
  When: _____
- ☐ ☐ Gynecological condition:
  _____

Other Conditions (digestive, emotional, mobility issues, etc.):
_____
_____

If required, please describe in further detail any medical conditions listed above: _____
_____
Current MEDICATIONS: _____
Current/Recent Surgery and/or Injury details: _____
What is the reason you are seeking Massage Therapy treatment? :_____

Initially reviewed in presence of Client, by RMT: _____