Client Information and Medical History

B A K
MASSAGE THERAPY CLINIC

An accurate health history is important to ensure that it is safe for you to receive a massage treatment.. If your health status changes in the future, please inform us. All information gathered is kept confidential except as required or allowed by law, or to facilitate diagnosis, assessment, or treatment. You will be asked to provide a written authorization for release of any information.

Name: _____ Date: _____
Address: _____ Tel: bus: _____ res: _____
_____ fax: _____ cell: _____
D.O.B. _____ gender: M / F e-mail: _____
(month / date / year)
Occupation: _____ General health status: _____

How did you hear about this clinic? _____ What is your primary complaint? _____

Please indicate conditions you are or have experienced:

* ☐ Cardiovascular
- ☐ High Blood Pressure
- ☐ Low Blood Pressure
- ☐ CCHF
- ☐ Heart Attack
- ☐ Phlebitis / Varicose Veins
- ☐ Stroke / CVA
- ☐ Pacemaker or similar device
- ☐ Heart Disease

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

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

* ☐ Other:
- ☐ Loss of Sensation
- ☐ Diabetes (onset: _____)
- ☐ Allergies/Hypersensitivity to: _____
- ☐ Epilepsy
- ☐ Cancer: _____
- ☐ Arthritis: _____

* ☐ Infections:
- ☐ Hepatitis
- ☐ Skin Conditions
- ☐ TB
- ☐ HIV
- ☐ Herpes

* ☐ Other Medical Conditions:
(e.g. digestive conditions, hemophilia, osteoporosis, mental illness, etc...)
_____
_____
_____
_____

* ☐ Women:
- ☐ Pregnant, due date: _____
- ☐ Gynecological conditions: _____
- ☐ Caesarian Section
- ☐ No. of Children: _____

* ☐ Soft Tissue/Joint Discomfort:
- ☐ Neck: _____
- ☐ Shoulders: _____
- ☐ Upper Back: _____
- ☐ Arms: _____
- ☐ Mid Back: _____
- ☐ Low Back: _____
- ☐ Hips / Pelvis: _____
- ☐ Legs: _____
- ☐ Knees: _____
- ☐ Ankles: _____
- ☐ Other:

_____
_____
_____
_____

Current Medications:
_____
_____

Condition(s) it treats:
_____
_____

Surgery: _____ date: _____
Nature:
_____

Injuries:
_____ date: _____
_____ date: _____

Primary Care Physician: _____
Address: _____
Phone Number: _____
Last Medical Visit: _____

Current involvement in other health care: yes/no?
If yes, please specify:
_____
_____

Do you have any internal pins, wires, artificial joints or special equipment? yes/no
please specify what and where:
_____