Confidential Patient Health History

Pacific Ave Massage Therapy

Date: _____

Name: _____ Birthdate: _____
First Last DD MM YY

Address: _____
Street City Postal Code

Home Phone: _____ Work Phone: _____ Cell Phone: _____

Referred by: _____ Email: _____ Occupation:_____

Physician Name: _____ Allergies: _____

Insurance Information

Insurance Provider _____

Policy Holder Name _____ Birthdate _____
DD MM YY

ID/Member Number _____ Policy Number _____

Have you had previous massage therapy? Yes ☐ No ☐

Are you presently undergoing alternative treatments? Yes ☐ No ☐
(example: Physiotherapy, Chiropractics, etc.)
If yes, please specify _____

Are you under any medical supervision? Yes ☐ No ☐

If yes, for what condition?
_____

Are you taking any medication? Yes ☐ No ☐

If yes, please specify type and reason for taking _____

Date of your last complete physical examination _____

What type of exercise/hobbies do you do weekly? _____

Have you ever been hospitalized for any reason?
If yes, please explain _____
_____

If an injury is present, is it due to a motor vehicle accident or workplace injury?

☐ Motor Vehicle ☐ Workplace ☐ Other

Please check if you have any of these conditions **presently** or in the **past**:

MUSCULOSKELETAL
___ migraines
___ tension headaches
___ low/mid back pain
___ jaw or ear pain
___ osteoporosis
___ rheumatoid arthritis
___ osteoarthritis
___ whiplash
___ fibromyalgia
___ repeated strains/sprains
___ postural condition
___ degenerative disc disease
___ shoulder pain

WOMEN ONLY
___ painful menstruation
___ endometriosis
___ pregnant (due date: _____)

CARDIOVASCULAR
___ high blood pressure
___ low blood pressure
___ hay fever
___ heart attack
___ varicose veins
___ hepatitis
___ pacemaker
___ poor circulation

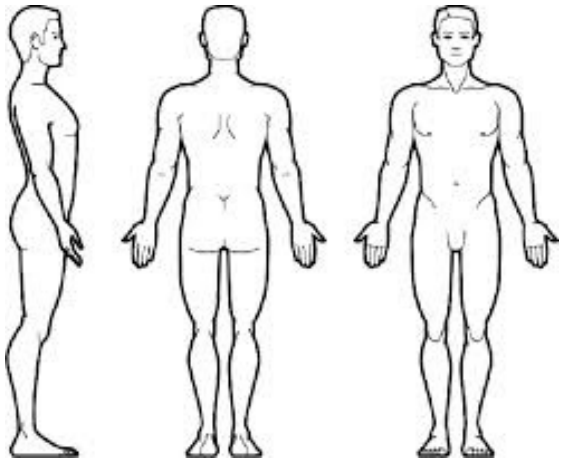
RESPIRATORY
___ difficulty breathing
___ hay fever
___ emphysema
___ COPD
___ asthma

SKIN
___ rashes
___ eczema

OTHER
___ MS
___ Parkinson's
___ Alzheimer's
___ hearing loss
___ depression
___ hyperthyroidism
___ hypothyroidism
___ diabetes 1
___ diabetes 2
___ cancer

INFECTIOUS
___ TB
___ HIV
___ herpes
___ hepatitis

On the diagram below, please circle any problematic areas.



OFFICE USE ONLY

Updated: Date: _____ Signature: _____

Date: _____ Signature: _____