Carlie Pitka

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Health History Form

For Your Information:

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 let me know. All information gathered for this treatment is confidential except as required or allowed by law or except to facilitate diagnosis (assessment) or treatment. You will be asked to provide written authorization for release of any information.

Personal Information

Name: _____ Today's Date: _____
Address: _____ Date of Birth: _____
City: _____ Postal Code: _____ Occupation: _____
Phone Number: _____ Work Number: _____
Primary Care Physician: _____ Phone Number: _____
Who Referred You? _____ Recreational activities: _____
What is your Primary Complaint? _____
How long have you had this condition? _____
What aggravates/ relieves this condition? _____
What are your goals for this massage treatment? _____

Other Health Care: □ Chiropractic: □ Physiotherapy: □ Other: _____
Overall Health: □ Good □ Fair □ Poor
Exercise: □ Competitive □ Recreational □ Rehabilitative
Dominant Hand: □ Left □ Right
Previous Massage Experience: □ Yes □ No
Good Sleeping Habits: □ Yes □ No
Regular Eating Habits: □ Yes □ No

Current medications and conditions it treats: _____
_____
Surgical operations (Include date): _____
_____
Major injuries/accidents (Include date): _____
_____
Of special note (pins, wires, plates, artificial joints, special equipment and location): _____
_____

Health History

□ Please indicate all current and past conditions you have experienced.

Head/Neck

□ Whiplash
□ Headache
□ Migraine
□ Concussion
□ Ringing in the ears
□ Hearing Impairment
□ Vision Impairment
□ Speech Impairment
□ TMJ (Jaw Pain)
□ Brain Injury

□ Other: _____

Respiratory

□ Asthma
□ Bronchitis
□ Emphysema
□ Pneumonia
□ Shortness of Breath
□ Sinusitis
□ Frequent Colds
□ Recurrent Lung Infection
□ Chronic Cough
□ Dizziness
□ Smoking

□ Other: _____

Cardiovascular

□ High Blood pressure: ___/___
□ Low Blood Pressure: ___/___
□ Heart Attack
□ Chronic Congestive Heart Failure
□ Chest Pain/Angina
□ Stroke
□ Pace Maker or Similar Device
□ Phlebitis
□ Hemophilia
□ Poor Circulation/Varicose Veins
□ heart Disease

□ Other: _____

Digestive
- ☐ Constipation
- ☐ Diarrhea
- ☐ Crohn's
- ☐ Irritable Bowel Syndrome
- ☐ Nausea
- ☐ Frequent Urination
- ☐ Poor Appetite
- ☐ Excessive Appetite
- ☐ Hiatus Hernia
- ☐ Ulcers
- ☐ Diverticula
- ☐ Other: _____

Nervous System
- ☐ Spinal Cord Injury
- ☐ Numbness
- ☐ Sensory (Change/Loss)
- ☐ Sciatica
- ☐ Thoracic Outlet Syndrome
- ☐ Tingling
- ☐ Seizures
- ☐ Multiple Sclerosis
- ☐ Cerebral Palsy
- ☐ Epilepsy
- ☐ Carpal Tunnel Syndrome
- ☐ Other: _____

Disease/Condition
- ☐ Fibromyalgia
- ☐ Chronic Fatigue Syndrome
- ☐ Allergies: _____
- ☐ Cancer: (Benign/Malignant) Treatment: _____
- ☐ Diabetes: (Type) _____ Onset: _____
- ☐ Liver
- ☐ Kidney
- ☐ Gallbladder
- ☐ Bladder
- ☐ Other: _____

Skin
- ☐ Frostbite
- ☐ Sensitive Skin
- ☐ Rash/Eruptions
- ☐ Contagious Condition
- ☐ Cold Sores
- ☐ Bruise Easily

- ☐ Other: _____

Infections
- ☐Hepatitis: (Type) _____
- ☐ Tuberculosis
- ☐ HIV/AIDS
- ☐ Skin Conditions
- ☐ Herpes
- ☐ Influenza
- ☐ Plantar Warts

- ☐ Other: _____

Muscle/Soft Tissue
- ☐ Pain
- ☐ Strain
- ☐ Stiffness
- ☐ Restricted Movement
- ☐ Tendonitis
- ☐ Poor Posture
- ☐ Weakness
- ☐ Spasm
- ☐ Other: _____

Bone/Joint
- ☐ Pain
- ☐ Sprain
- ☐ Swelling
- ☐ Limited Movement
- ☐ Dislocation
- ☐ Fracture
- ☐ Arthritis: (OA/RA)
- ☐ Degenerative Disc Disease
- ☐ Prolapsed/herniated Disc
- ☐ Osteoporosis
- ☐ Bursitis
- ☐ Other: _____

Soft Tissue/Joint discomfort
- ☐ Neck
- ☐ Shoulder
- ☐ Arm
- ☐ Wrist/Hand
- ☐ Upper Back
- ☐ Mid Back
- ☐ Low Back
- ☐ Hips
- ☐ Legs
- ☐ Knees
- ☐ Feet
- ☐ Other: _____

Women Only
- ☐ Pregnancy Due Date: _____
- ☐ Vaginal Birth
- ☐ Gynecological Conditions: _____
- ☐ Number of Children: _____

- ☐ Other: _____

CONSENT TO TREATMENT

I hereby consent to the massage therapy treatment as described by my therapist. I understand and agree to the techniques that will be used, their desired effects and possible side effects, and the anticipated duration of the treatment. I understand that I have the right to ask questions about my treatment and to stop, or alter my treatment, and also to clarify the reason for particular techniques being used in my treatment. I agree to take responsibility for my health and lifestyle choices.

Date: _____ Signature: _____