EPIPHANY SPA & BOUTIQUE

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

Name: ______________________ **Telephone (residential):** ______________________

Address: ______________________ **(business)**: ______________________

City: ______________ **Postal Code:** ______________ **Email:** ______________

Date Of Birth (mm/dd/yy): ______________ **Occupation:** ______________

Who referred you? ______________________

Consent to Treatment: I provide my full voluntary and informed consent to treatment. I understand that I may change my mind regarding any aspect of my treatments at any time and upon informing my therapist of my decision. I may withdraw consent with the intent to alter or discontinue the treatment. Minors (16 years of age or under) must have a parent or legal guardian sign below to indicate consent to treatment.

Signature: ______________________ **Date:** ______________________

Health History : Please indicate conditions you have or are experiencing.

RESPIRATORY
___chronic cough
___shortness of breath
___bronchitis
___asthma
___emphysema

CARDIOVASCULAR
___high blood pressure
___low blood pressure
___CCHF
___heart attack
___stroke/CVA
___pacemaker or similar
___heart disease
___varicose veins
___phlebitis

DIGESTION
___difficult digestion
___poor appetite
___excessive appetite
___constipation
___nausea
___liver/gall bladder

OTHER CONDITIONS
___loss of sensation
___diabetes
(onset: ______________)
___allergies
(i.e. anaphylaxis/skin irritation)
___epilepsy
___cancer
___arthritis

HEAD/NECK
___vision problems
___vision loss
___ear problems
___hearing loss

INFECTIONS
___hepatitis
___TB
___HIV

SKIN CONDITIONS
___psoriasis
___eczema
___contagious conditions (specify: ______________)

WOMEN
___pregnant (due: ______________)

MENSTRUATION
___heavy
___painful
___soft tissue joint discomfort & its nature
___neck: ______________
___low back: ______________
___mid back: ______________
___upper back: ______________
___arms: ______________
___legs: ______________
___knees: ______________
___other: ______________

What is your primary complaint?
____
____

What is your general health status?
____
____

Current Medications: ______________________ **Primary Care Physician:** ______________________

Condition it treats: ______________________ **Address:** ______________________

Surgery: ______________________ **Date:** ______________________

Nature: ______________________ **Involvement in other health care: Yes** ___ **No** ___

Injury: ______________ **Date:** ______________ **If yes, please specify** ______________

Other Medical Conditions
(ie. digestive, hemophilia, etc)

Of Special Note
(presence of internal pins, artificial joints, etc)