EQUIVITA

The Science of Fitness. The Art of Wellness.

Health History Form
For Therapeutic Massage

Thank you for choosing EQUIVITA for therapeutic massage. A health history is important to providing the best possible experience by your massage therapist. Please complete this form prior to your first massage.

How did you hear about EQUIVITA? ❑ Friend _____ ❑ printed advertisement ❑ radio ❑ television ❑ web site ❑ physician ❑ other

Demographic Information — Phone No.s — Hours

Full Name: _____ Work Phone: _____ _____ Today's Date: _____

Address: _____ Home Phone: _____ _____ Date of Birth: _____

City, State, Zip: _____ Cell Phone: _____ _____ Age: _____

Occupation: _____ E-Mail: _____ Gender: M F

Emergency Contact Information — Phone No.s — Hours

Emergency Contact: _____ Work Phone: _____ _____

Relationship: _____ Home Phone: _____ _____

Address _____ Cell Phone: _____ _____

City, State, Zip: _____

Medical Providers (please use additional page if necessary)

Medical Provider (1): _____ Specialty: _____ Practice Name: _____

Address: _____ Phone: _____ _____

City, State, Zip _____ Fax: _____ _____

Medical Provider (2): _____ Specialty: _____ Practice Name: _____

Address: _____ Phone: _____ _____

City, State, Zip: _____ Fax: _____ _____

General Health History Questions

1. Have you had therapeutic massage before? ❑ Yes ❑ No

2. List any current medications:

Medication	Condition Prescribed For

3. Are you wearing any medication patches? If so, where are they located?

4. Please list all allergies (including allergies to nuts, oils and detergents).

5. Please list any ongoing chronic conditions.

6. (Women Only) Are you pregnant or nursing? If pregnant, how many weeks?

7. How would you describe your stress level? Low, Medium or High?

8. List and explain. Include date and treatment received for the following:

Surgeries: _____

Accidents: _____

Major Illnesses: _____

9. Please check the **first** box for any symptoms or conditions that you **currently** experience, and the **second** box for any that you have experienced in the **past**:

General

Curr.	Past	
❑	❑	Cold/Flu
❑	❑	Fatigue
❑	❑	Fever
❑	❑	Headaches
❑	❑	Open Lesions or Wounds
❑	❑	Sinus
❑	❑	Sleep Disturbances
❑	❑	Other _____

Skin Conditions

Curr.	Past	
❑	❑	Eczema
❑	❑	Psoriasis
❑	❑	Warts, Athletes foot
❑	❑	Other _____

Respiratory, Cardiovascular

Curr.	Past	
❑	❑	Anemia
❑	❑	Asthma
❑	❑	Clotting Disorders
❑	❑	Heart Disease/Conditions
❑	❑	High Blood Pressure
❑	❑	Stroke
❑	❑	Pneumonia
❑	❑	Thrombophlebitis
❑	❑	Varicose Veins
❑	❑	Other _____

Muscles and Joints

Curr.	Past	
❑	❑	Baker's Cysts
❑	❑	Bursitis, Tendonitis
❑	❑	Ganglion Cysts
❑	❑	Fibromyalgia
❑	❑	Fractures
❑	❑	Dislocations
❑	❑	Hernia
❑	❑	Herniated Disc
❑	❑	Osteoporosis
❑	❑	Osteoarthritis
❑	❑	Paget's Disease
❑	❑	Rheumatoid Arthritis
❑	❑	Scoliosis
❑	❑	Septic Arthritis
❑	❑	Spasms, Cramps
❑	❑	Strains, Sprains
❑	❑	Thoracic Outlet Syndrome
❑	❑	Torticollis, Wry neck
❑	❑	TMJ
❑	❑	Whiplash
❑	❑	Other _____

Lymph and Immune

Curr.	Past	
❑	❑	Chronic Fatigue Syndrome
❑	❑	Edema
❑	❑	HIV/AIDS
❑	❑	Hodgkin's Disease
❑	❑	Lupus
❑	❑	Other _____

Nervous System

Curr.	Past	
❑	❑	Carpal Tunnel Syndrome
❑	❑	Depression
❑	❑	Epilepsy
❑	❑	Seizure Disorders
❑	❑	Sciatica
❑	❑	Reduced Sensations
❑	❑	Raynauds Disease
❑	❑	Other _____

Endocrine System

Curr.	Past	
❑	❑	Diabetes
❑	❑	Thyroid dysfunction
❑	❑	Other _____

Urinary

Curr.	Past	
❑	❑	Kidney Disease
❑	❑	Other _____

Digestive

Curr.	Past	
❑	❑	Crohn's Disease
❑	❑	Irritable Bowel Syndrome
❑	❑	Ulcers
❑	❑	Other _____

Reproductive

Curr.	Past	
❑	❑	Ovarian cysts
❑	❑	Painful Menstruation
❑	❑	Other _____

Cancer/Tumor

Curr.	Past	Comments/locations
❑	❑	Benign _____
❑	❑	Malignant _____
❑	❑	Palpable Tumors _____

Why are you here today?

10. What are your goals for receiving therapeutic massage? (i.e. relaxation, pain relief)

11. If you are experiencing pain, describe what you do that causes pain.

12. What activities make it better?

13. What activities make it worse?

14. What questions do you have about massage?

Signature and Return Information

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Thank you for choosing EQUIVITA.
Visit us on the web at www.equivita.com.

Please return this form to EQUIVITA via fax, mail, or in person:
Fax: 888.216.8339
Mail: EQUIVITA 1508 Hess St. Suite D, Grandview, OH 43212

I acknowledge the above information is true and accurate. _____ Signature _____ Date

Signature of Parent or Guardian if under age 18. _____ Signature _____ Date

The information on this form is confidential. To protect your privacy written permission is required for release of any information.

EMHHF 7/06