

Health History Information

Surgeries _____

Major illnesses/ hospitalizations _____

Injuries or accidents still affecting you _____

Please mark any of the following conditions you are currently dealing with, or have dealt with in the past. Mark with a **C** for Current, or **P** for Past. Please use the space next to each item for details when applicable. Leave blank if it doesn't apply to you.

___ tendonitis _____
___ bursitis _____
___ arthritis _____
___ broken bones _____
___ osteoporosis _____
___ sprains/strains _____
___ carpal tunnel _____
___ disc problems _____
___ whiplash _____
___ chronic tension headaches _____
___ migraines _____
___ head injury _____
___ heart condition _____
___ blood clots _____
___ varicose veins _____
___ high/ low blood pressure _____
___ sinus problems _____
___ allergies _____
___ asthma _____
___ emphysema _____
___ other _____

___ rashes _____
___ athletes foot _____
___ psoriasis/eczema _____
___ ulcers _____
___ irritable bowel syndrome _____
___ chronic constipation _____
___ kidney infections/disease _____
___ crohn's disease _____
___ fibromyalgia _____
___ cancer/ tumors _____
___ stroke _____
___ diabetes _____
___ hepatitis C _____
___ chronic fatigue _____
___ suppressed immune system _____
___ insomnia _____
___ depression _____
___ anxiety _____

For women only:

___ endometriosis _____
___ fibroids _____
___ pregnancy _____

I have stated all medical conditions that I am aware of and will update my therapist of any changes in my health. I understand that massage treatments are my personal financial responsibility and I agree to pay for these services at the time of treatment unless other arrangements have been made. I will provide **Caroline Brady LMP**, with at least **24 hours notice** if I need to cancel or reschedule an appointment. I understand that I will be charged in full for any appointment broken with less than **24 hours notice**.

Signed _____ Date _____