HEALTH HISTORY FORM

NAME (please print) : _____ DOB (dd/mm/yr): _____
Address: _____
Primary Phone: _____
Email: _____
Occupation: _____ (if retired, from what?)

Family Doctor: _____ Date of Last Check-Up: _____
Physician's Address: _____
Physician's Phone: _____

Emergency Contact: _____
Phone Number: _____

How did you find me?_____
If you were referred to me, by who? _____

CONSENT FOR PERSONAL INFORMATION

I certify that the information given in this form is correct and accurately reflects my past and current health status. I will notify the therapist of any changes that occur as soon as possible. I understand that the information requested will assist my therapist in treating me safely and that I can ask questions regarding this information. I am aware that before each massage I will give consent for treatment; I am also aware that my consent may be revoked at any time I choose. This information will be kept confidential unless required by law or after I have given written consent to release information.

* I agree to provide 24 hours notice to change or cancel my appointment or I will be charged the full appointment fee.*

Date: _____ Signature: _____

❑ I give permission for the clinic to contact me via mail or email (e.g. Newsletters, cards, etc.)

What brings you in for massage? _____
I have had massage therapy before: _____ yes _____no
If so what did you like or dislike?
Liked: _____Disliked: _____

Special Considerations	*Current Medication(s) & Reason for Use*
❑ pacemaker ❑ artificial joint(s) or limb(s) ❑ rods, pins, wires, or valves ❑ implants ❑ walking aid(s) ❑ chemo or drug port ❑ other:	_____ _____ _____ _____ _____ ❑ I use supplements/vitamins/remedies

SYSTEMS OVERVIEW

Respiratory
- ❑ Bronchitis/Chronic Cough
- ❑ Asthma
- ❑ Emphysema
- ❑ Other:

Cardiovascular
- ❑ High Blood Pressure
- ❑ Low Blood Pressure
- ❑ Angina
- ❑ Heart Attack
- ❑ Congestive Heart Failure
- ❑ Phlebitis
- ❑ Poor Circulation
- ❑ Blood Clots
- ❑ Other:

Central Nervous System
- ❑ Epilepsy
- ❑ TIA/Stroke
- ❑ Multiple Sclerosis
- ❑ Parkinsonism
- ❑ Other:

Infectious Conditions
- ❑ Hepatitis *Type*: _____
- ❑ HIV/AIDS
- ❑ Tuberculosis
- ❑ Other:

Skin Conditions
- ❑ Infectious Condition
- ❑ Warts, Herpes
- ❑ Eczema
- ❑ Psoriasis
- ❑ Other:

Allergies
- ❑ Nuts
- ❑ Oils, Creams, Lotions
- ❑ Aromas, Airborne
- ❑ Latex
- ❑ Drug Allergy
- ❑ History of Anaphylaxis
- ❑ Other:

Musculoskeletal
c = current p = previous
- ❑ ___ Neck Problem
- ❑ ___ Shoulder Problem
- ❑ ___ Arm Problem

(continued)
- ❑ ___ Wrist Problem
- ❑ ___ Hand Problem
- ❑ ___ Mid Back Problem
- ❑ ___ Low Back Problem
- ❑ ___ Hip Problem
- ❑ ___ Knee Problem
- ❑ ___ Ankle Problem
- ❑ ___ Foot Problem

Altered Sensation

Where:

Arthritis

Type:
Frequency:

Surgeries

Year: Type:
_____ _____
_____ _____
_____ _____

Complications:

Injuries

Year: Type:
_____ _____
_____ _____
_____ _____

Complications:

Cancer
c = current p = previous
- ❑ ___ Chemotherapy
- ❑ ___ Radiation
- ❑ ___ Antibiotics

Digestion / Urination
- ❑ Constipation
- ❑ Irritable Bowel Syndrome
- ❑ Crohn's Disease
- ❑ Kidney Disease
- ❑ Recurrent Infection
- ❑ Prostate Problem
- ❑ Other:

Diabetes

Type:
Year Diagnosed:
Complications:

Hearing / Vision
- ❑ Hearing Impairment
- ❑ Visual Impairment

Women
- ❑ Pregnant *Week*: _____
- ❑ High Risk Pregnancy
- ❑ Menstruation Issues
- ❑ Menopause Issues
- ❑ Breast Pain
- ❑ Breastfeeding
- ❑ Endometriosis

Other Health Care
c = current p = previous
- ❑ ___ Physiotherapy
- ❑ ___ Chiropractic
- ❑ ___ Naturopathy
- ❑ ___ Psychotherapy
- ❑ ___ Medical Specialist
- ❑ ___ Other:

Types of Regular Exercise & How Often: