

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 (yearly newsletter/ updates)

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

- pacemaker
- artificial joint(s) or limb(s)
- rods, pins, wires, or valves
- implants
- walking aid(s)
- chemo or drug port
- other: _____

Current Medication(s) & Reason for Use

I use supplements/vitamins/remedies

SYSTEMS OVERVIEW

<p>Respiratory</p> <ul style="list-style-type: none"> <input type="checkbox"/> Bronchitis/Chronic Cough <input type="checkbox"/> Asthma <input type="checkbox"/> Emphysema <input type="checkbox"/> Other: 	<p>Musculoskeletal <i>c = current p = previous</i></p> <ul style="list-style-type: none"> <input type="checkbox"/> ___ Neck Problem <input type="checkbox"/> ___ Shoulder Problem <input type="checkbox"/> ___ Arm Problem 	<p>Cancer <i>c = current p = previous</i></p> <ul style="list-style-type: none"> <input type="checkbox"/> ___ Chemotherapy <input type="checkbox"/> ___ Radiation <input type="checkbox"/> ___ Antibiotics
<p>Cardiovascular</p> <ul style="list-style-type: none"> <input type="checkbox"/> High Blood Pressure <input type="checkbox"/> Low Blood Pressure <input type="checkbox"/> Angina <input type="checkbox"/> Heart Attack <input type="checkbox"/> Congestive Heart Failure <input type="checkbox"/> Phlebitis <input type="checkbox"/> Poor Circulation <input type="checkbox"/> Blood Clots <input type="checkbox"/> Other: 	<ul style="list-style-type: none"> <input type="checkbox"/> ___ Wrist Problem <input type="checkbox"/> ___ Hand Problem <input type="checkbox"/> ___ Mid Back Problem <input type="checkbox"/> ___ Low Back Problem <input type="checkbox"/> ___ Hip Problem <input type="checkbox"/> ___ Knee Problem <input type="checkbox"/> ___ Ankle Problem <input type="checkbox"/> ___ Foot Problem 	<p>Digestion / Urination</p> <ul style="list-style-type: none"> <input type="checkbox"/> Constipation <input type="checkbox"/> Irritable Bowel Syndrome <input type="checkbox"/> Crohn's Disease <input type="checkbox"/> Kidney Disease <input type="checkbox"/> Recurrent Infection <input type="checkbox"/> Prostate Problem <input type="checkbox"/> Other:
<p>Central Nervous System</p> <ul style="list-style-type: none"> <input type="checkbox"/> Epilepsy <input type="checkbox"/> TIA/Stroke <input type="checkbox"/> Multiple Sclerosis <input type="checkbox"/> Parkinsonism <input type="checkbox"/> Other: 	<p>Altered Sensation</p> <p>Where:</p>	<p>Diabetes</p> <p>Type:</p> <p>Year Diagnosed:</p> <p>Complications:</p>
<p>Infectious Conditions</p> <ul style="list-style-type: none"> <input type="checkbox"/> Hepatitis Type: _____ <input type="checkbox"/> HIV/AIDS <input type="checkbox"/> Tuberculosis <input type="checkbox"/> Other: 	<p>Arthritis</p> <p>Type:</p> <p>Frequency:</p>	<p>Hearing / Vision</p> <ul style="list-style-type: none"> <input type="checkbox"/> Hearing Impairment <input type="checkbox"/> Visual Impairment
<p>Skin Conditions</p> <ul style="list-style-type: none"> <input type="checkbox"/> Infectious Condition <input type="checkbox"/> Warts, Herpes <input type="checkbox"/> Eczema <input type="checkbox"/> Psoriasis <input type="checkbox"/> Other: 	<p>Surgeries</p> <p>Year: _____ Type: _____</p> <p>_____</p> <p>_____</p> <p>Complications:</p>	<p>Women</p> <ul style="list-style-type: none"> <input type="checkbox"/> Pregnant Week: _____ <input type="checkbox"/> High Risk Pregnancy <input type="checkbox"/> Menstruation Issues <input type="checkbox"/> Menopause Issues <input type="checkbox"/> Breast Pain <input type="checkbox"/> Breastfeeding <input type="checkbox"/> Endometriosis
<p>Allergies</p> <ul style="list-style-type: none"> <input type="checkbox"/> Nuts <input type="checkbox"/> Oils, Creams, Lotions <input type="checkbox"/> Aromas, Airborne <input type="checkbox"/> Latex <input type="checkbox"/> Drug Allergy <input type="checkbox"/> History of Anaphylaxis <input type="checkbox"/> Other: 	<p>Injuries</p> <p>Year: _____ Type: _____</p> <p>_____</p> <p>_____</p> <p>Complications:</p>	<p>Other Health Care <i>c = current p = previous</i></p> <ul style="list-style-type: none"> <input type="checkbox"/> ___ Physiotherapy <input type="checkbox"/> ___ Chiropractic <input type="checkbox"/> ___ Naturopathy <input type="checkbox"/> ___ Psychotherapy <input type="checkbox"/> ___ Medical Specialist <input type="checkbox"/> ___ Other:

Types of Regular Exercise & How Often: