Health History Form

FOR YOUR INFORMATION

An accurate health history is important to ensure that it is safe for you to receive a massage therapy treatment. If your health status changes in the future, please let us know. All information gathered for this treatment is confidential. Email addresses are used for appointment confirmations, reminders, cancellations, and occasional clinic news on holidays hours and services. We will NEVER give out your email address. Follow-up appointments can be booked with the same therapist or different therapist depending on your schedule or treatment style preference.

Name _____ Date _____

Address _____ Apt # _____ City _____ Postal _____

Phone #: Home _____ Bus. _____ Email _____

Cell _____ Date of Birth ____/____/____ (Day / Month / Year) Occupation _____

What is your primary reason for receiving massage therapy? _____

What is you general health status? _____

What other treatment have you tried? Please indicate if received previously or currently:

Chiropractic _____ Acupuncture _____ Physician _____

Massage _____ Physiotherapy _____ Naturopath _____

Did a health care practitioner refer you for Massage Therapy? (ie: Doctor, Chiro, Physio, Naturopath etc.) ( ) Yes ( ) No

If Yes, please provide their name and address: _____

How did you hear about the clinic? Web:( ): If yes, please let us know how _____ Yellow Pages: ( )
Sign:( ) Word of Mouth: ( ) If yes, please provide name: _____ Other: ( ) _____

HEALTH HISTORY: Please indicate conditions you are experiencing, or have experienced.

Respiratory

Previous	Current	
☐	☐	Chronic cough
☐	☐	Shortness of breath
☐	☐	Bronchitis
☐	☐	Asthma
☐	☐	Emphysema

Cardiovascular

☐	☐	High blood pressure
☐	☐	Low blood pressure
☐	☐	Heart disease
☐	☐	Heart attack
☐	☐	Phlebitis
☐	☐	Stroke/CVA

Other Conditions

☐	☐	Skin conditions
☐	☐	Constipation

Is there a family history of any of the above? ( ) Yes ( ) No

Other Conditions

Previous	Current	
☐	☐	Diabetes Mellitus
☐	☐	Epilepsy
☐	☐	Loss of sensation
☐	☐	Cancer
☐	☐	Arthritis
☐	☐	Allergies

Head/Neck

☐	☐	Headaches
☐	☐	Vision loss
☐	☐	Hearing loss
☐	☐	Ear problems

Infections

☐	☐	Tuberculosis
☐	☐	HIV
☐	☐	Hepatitis

Is there a family history of any of the above? ( ) Yes ( ) No

Women

Previous	Current	
☐	☐	Pregnant: due
☐	☐	Gynaecological conditions
☐	☐	Cesarean section
☐	☐	Breast pain/tenderness

Soft tissue/joint discomfort

☐	☐	Neck
☐	☐	Upper back
☐	☐	Mid back
☐	☐	Lower back
☐	☐	Shoulders
☐	☐	Arms
☐	☐	Legs
☐	☐	Knees
☐	☐	Feet
☐	☐	Hips
☐	☐	Other

Therapist Notes:

Date of Initial Health History: _____
Update 1 _____
Update 2 _____
Update 3 _____
Update 4 _____

Please Turn Page Over