



Health History Form

An accurate health history is important to ensure that it is safe for you to receive a massage treatment. If your health status changes in the future, please let the therapist know. All information gathered for this treatment is confidential except as required or allowed by law or except to facilitate diagnosis (assessment) or treatment.

Personal Information

Last name *First name* *Date of Birth (day/month/year)* *Occupation*

Street *City* *Province* *Postal Code*

Telephone - Home *Telephone – Work*

Physician's Name *Address* *Telephone*

Email Address *Source of Referral*

Are you with Blue Cross or another company? If Blue Cross- Policy # I.D. #

How did you hear about us?

Current Health Status

What is your primary complaint?

Are you currently receiving any form of treatment from another health care practitioner?

Please list any medications you are taking or have recently taken and why?

Do you partake in any of the following lifestyle habits regularly?

- Exercise Alcohol/Drugs Caffeine Smoking Water

What would you consider your stress level to be on a scale of one to ten?

Medical History

Please indicate if you have sustained any injuries or accidents to this date:

Injury/ Accident	Time of and nature of injury/accident

Please indicate if you have received any surgery to this date:

Surgical Procedure	Time and Nature of surgery

Please check if any of the following pertain to you:

<p>Cardiovascular</p> <input type="checkbox"/> High blood pressure <input type="checkbox"/> Low blood pressure <input type="checkbox"/> Chronic Congestive Heart Failure <input type="checkbox"/> Heart Disease <input type="checkbox"/> Myocardial Infarction <input type="checkbox"/> Phlebitis <input type="checkbox"/> Cerebro-vascular accident (Stroke) <input type="checkbox"/> Presence of a pace maker or similar device <input type="checkbox"/> Hemophilia <input type="checkbox"/> General circulatory disorder <input type="checkbox"/> Varicose veins <input type="checkbox"/> Dizziness <input type="checkbox"/> Chest pain <input type="checkbox"/> Other	<p>Respiratory</p> <input type="checkbox"/> Chronic cough <input type="checkbox"/> Bronchitis <input type="checkbox"/> Shortness of breath <input type="checkbox"/> Asthma <input type="checkbox"/> Emphysema <input type="checkbox"/> Other	<p>Regional Areas of Concern</p> <input type="checkbox"/> Neck/ Head/ Face <input type="checkbox"/> Shoulder <input type="checkbox"/> Arm <input type="checkbox"/> Chest/ Abdomen <input type="checkbox"/> Spine <input type="checkbox"/> Pelvis <input type="checkbox"/> Hip <input type="checkbox"/> Leg <input type="checkbox"/> Hands/ Feet <input type="checkbox"/> Muscle weakness <input type="checkbox"/> Muscle soreness <input type="checkbox"/> Pins, plate, needles, implants <input type="checkbox"/> Artificial joints <input type="checkbox"/> Cosmetic implants <input type="checkbox"/> Arthritis <input type="checkbox"/> Osteoporosis <input type="checkbox"/> Other	<p>Allergies</p> <input type="checkbox"/> Known allergies or Hypersensitivities
<p>Renal</p> <input type="checkbox"/> Kidney stones <input type="checkbox"/> Dialysis <input type="checkbox"/> Nephritis <input type="checkbox"/> Other	<p>Infectious Diseases</p> <input type="checkbox"/> Infectious skin conditions <input type="checkbox"/> Tuberculosis <input type="checkbox"/> Hepatitis <input type="checkbox"/> HIV <input type="checkbox"/> Other	<p>Neurological</p> <input type="checkbox"/> Epilepsy <input type="checkbox"/> Multiple Sclerosis <input type="checkbox"/> Loss of sensation <input type="checkbox"/> Neuritis <input type="checkbox"/> Other	<p>Medical Conditions</p> <input type="checkbox"/> Anaphylaxis <input type="checkbox"/> Skin irritations
	<p>Gastrointestinal</p> <input type="checkbox"/> Prolonged constipation <input type="checkbox"/> Irritable Bowl Syndrome <input type="checkbox"/> Chronic abdominal discomfort <input type="checkbox"/> Diarrhea <input type="checkbox"/> Other		<p>Reproductive</p> <input type="checkbox"/> Diabetes <input type="checkbox"/> Cancer <input type="checkbox"/> Skin conditions
			<p>Special Senses</p> <input type="checkbox"/> Pregnancy <input type="checkbox"/> Endometriosis <input type="checkbox"/> Pelvic Inflammatory Disease <input type="checkbox"/> Prostate condition
			<input type="checkbox"/> Vision Problems <input type="checkbox"/> Vision loss <input type="checkbox"/> Hearing loss <input type="checkbox"/> Altered taste <input type="checkbox"/> Altered smell

I, _____, verify that the information given on this form is true to the best of my knowledge and consent to massage therapy treatments as described by the massage therapist. I authorize the release of any relevant medical information to help further my treatment. I am aware that payment is due prior to each individual massage therapy treatment.

X

Signature

Date

Clinic Policy

- Clients are expected to be punctual, as your treatment time has been reserved for you.
- Full treatment fee is applied for missed appointments without 24 hours notice.
- Proper dress, i.e.: loose fitting shorts, sports bra, tube/ tank top, bikini garments are to be worn to better facilitate the treatment.
- If you are unsatisfied for any reason, please let me know, if you have more energy, less pain and more freedom, please let your friends know!!