

The information request below will assist us in treating you safely. Feel free to ask any questions about the information being requested. Please note that all information provided below will be kept confidentially, unless allowed or required by law. Your written permission will be required to release any information.

CONTACT/PERSONAL INFORMATION

Name: _____ Date of Birth: _____ Age: _____
 Address: _____ City: _____ Postal Code: _____
 Phone #: _____ Alternate Phone #: _____ CELL WORK OTHER (circle one)
 E-Mail address: _____
 Occupation: _____ Employer: _____

HEALTH INFORMATION

Please check **C** for current conditions and **P** for past conditions

<p>C P Cardiovascular</p> <p><input type="checkbox"/> high blood pressure</p> <p><input type="checkbox"/> low blood pressure</p> <p><input type="checkbox"/> chronic congestive heart failure</p> <p><input type="checkbox"/> heart attack <i>Date:</i> _____</p> <p><input type="checkbox"/> varicose veins / phlebitis</p> <p><input type="checkbox"/> stroke / cerebrovascular accident</p> <p><input type="checkbox"/> blood clots</p> <p><input type="checkbox"/> Reynaud's</p> <p><input type="checkbox"/> pacemaker or other device</p> <p><input type="checkbox"/> heart disease</p> <p><i>Is there a family history of any of the above?</i></p> <p><input type="checkbox"/> YES <input type="checkbox"/> NO <i>list:</i> _____</p> <p>C P Respiratory</p> <p><input type="checkbox"/> chronic cough</p> <p><input type="checkbox"/> shortness of breath</p> <p><input type="checkbox"/> bronchitis</p> <p><input type="checkbox"/> asthma</p> <p><input type="checkbox"/> emphysema / COPD</p> <p><input type="checkbox"/> Cystic Fibrosis</p> <p><i>Is there a family history of any of the above?</i></p> <p><input type="checkbox"/> YES <input type="checkbox"/> NO <i>list:</i> _____</p> <p><input type="checkbox"/> sinusitis</p> <p><input type="checkbox"/> pneumonia</p> <p>C P Nervous System</p> <p><input type="checkbox"/> concussion</p> <p><input type="checkbox"/> spinal cord injury</p> <p><input type="checkbox"/> nerve damage</p> <p><input type="checkbox"/> tingling / numbness</p> <p><i>Where?</i> _____</p>	<p>C P Musculoskeletal</p> <p><input type="checkbox"/> arthritis (osteo/rheumatoid)</p> <p><i>Is there a family history?</i> <input type="checkbox"/> YES <input type="checkbox"/> NO</p> <p><input type="checkbox"/> Osteoporosis / bone disease</p> <p><input type="checkbox"/> fractures / broken bones</p> <p><input type="checkbox"/> postural deformity (scoliosis etc.)</p> <p><input type="checkbox"/> sprain / strain</p> <p><input type="checkbox"/> muscle spasm</p> <p><input type="checkbox"/> tendinitis / bursitis</p> <p><input type="checkbox"/> jaw pain (TMJ)</p> <p><input type="checkbox"/> whiplash</p> <p><input type="checkbox"/> carpal tunnel syndrome</p> <p><input type="checkbox"/> degenerative disk disease</p> <p>C P Infection</p> <p><input type="checkbox"/> hepatitis</p> <p><input type="checkbox"/> HIV</p> <p><input type="checkbox"/> Tuberculosis</p> <p><input type="checkbox"/> herpes</p> <p><input type="checkbox"/> skin conditions</p> <p><i>list</i> _____</p> <p>C P Skin</p> <p><input type="checkbox"/> Eczema / Dermatitis</p> <p><input type="checkbox"/> Psoriasis</p> <p><input type="checkbox"/> severe acne</p> <p><i>Where?</i> _____</p> <p>C P Men</p> <p><input type="checkbox"/> Prostate Disease</p>	<p>C P Head / Neck</p> <p><input type="checkbox"/> history of headaches</p> <p><input type="checkbox"/> history of migraines</p> <p><input type="checkbox"/> vision problems</p> <p><input type="checkbox"/> vision loss</p> <p><input type="checkbox"/> ear problems</p> <p><input type="checkbox"/> hearing loss</p> <p>C P Digestive</p> <p><input type="checkbox"/> IBS</p> <p><input type="checkbox"/> Chrohn's / Colitis</p> <p><input type="checkbox"/> GERD (acid reflux)</p> <p><input type="checkbox"/> Gall Bladder disorder</p> <p>C P Other</p> <p><input type="checkbox"/> Epilepsy</p> <p><input type="checkbox"/> Diabetes <i>Type</i> ___ <i>Onset</i> _____</p> <p><input type="checkbox"/> loss of sensation <i>Where?</i> _____</p> <p><input type="checkbox"/> Cancer <i>Where?</i> _____</p> <p><input type="checkbox"/> Thyroid disease</p> <p><input type="checkbox"/> Depression</p> <p><input type="checkbox"/> Pins/ Wires / Joint replacement</p> <p><i>Where?</i> _____</p> <p>C P Women</p> <p><input type="checkbox"/> Pregnancy</p> <p><input type="checkbox"/> Gynaecological condition</p> <p><i>list</i> _____</p> <p><input type="checkbox"/> Menopause</p> <p><input type="checkbox"/> Painful Menses</p> <p><input type="checkbox"/> Fibrotic cysts</p>
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Do you have any other medical conditions (e.g. haemophilia, kidney disease, Parkinson's disease etc.)? YES NO

If yes please list: _____

Health History Form (continued)

MEDICATION

Please list any medications and the associated conditions (e.g. celebrex – arthritis): _____

Please list any supplements or herbal remedies: _____

Have you taken any pain relievers or anti-inflammatory medication today? (i.e. Tylenol, ibuprofen etc.)? YES NO

If yes please list: _____

ALLERGIES

Please list any allergies or hypersensitivities: _____

What type of reaction? _____

Do you carry an Epi-Pen? YES NO

SURGERY/TRAUMA

Please list all surgeries, motor vehicle accidents, severe physical trauma or athletic injuries, include an approximate date.

_____ Date: _____

_____ Date: _____

_____ Date: _____

_____ Date: _____

GENERAL INFORMATION

Overall, how is your general health? _____

Primary Care Physician: _____ Address: _____

Did a health care practitioner refer you for massage therapy? YES NO

If yes, please provide their name and address: _____

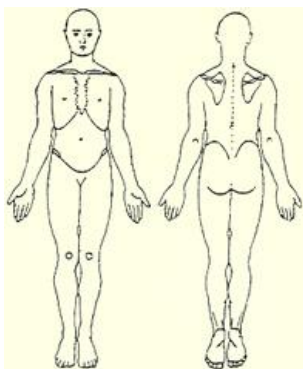
If no, how did you find us?: _____

Have you received massage therapy before? YES NO If yes, how often? _____

Reason for your appointment: _____

Are you currently receiving treatment from another health care professional: YES NO

If yes, for what? _____



Please circle any areas of tissue or joint discomfort

I hereby declare that the information I have provided is a complete and accurate account of my health information. I understand that it is my responsibility to inform my Massage Therapist of any changes to the above information immediately upon my next scheduled visit.

Client Name (PRINT): _____

Client Signature: _____

Cancellation Policy:

*A cancellation fee will be charged, at the discretion of the Therapist, for any appointments **missed or cancelled with less than 24 hours notice.***

Date of Initial Health History:

Update 1: _____

Update 2: _____

Update 3: _____

Update 4: _____