Body*KNEADS* Health Centre
148 Prescott St.
Kemptville, ON • K0G 1J0

Confidential

Health History Form

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

C P Cardiovascular
☐☐ high blood pressure
☐☐ low blood pressure
☐☐ chronic congestive heart failure
☐☐ heart attack *Date:* _____
☐☐ varicose veins / phlebitis
☐☐ stroke / cerebrovascular accident
☐☐ blood clots
☐☐ Reynaud's
☐☐ pacemaker or other device
☐☐ heart disease
Is there a family history of any of the above?
☐ YES ☐ NO *list:* _____

C P Respiratory
☐☐ chronic cough
☐☐ shortness of breath
☐☐ bronchitis
☐☐ asthma
☐☐ emphysema / COPD
☐☐ Cystic Fibrosis
Is there a family history of any of the above?
☐ YES ☐ NO *list:* _____
☐☐ sinusitis
☐☐ pneumonia

C P Nervous System
☐☐ concussion
☐☐ spinal cord injury
☐☐ nerve damage
☐☐ tingling / numbness
*Where?*_____

C P Musculoskeletal
☐☐ arthritis (osteo/rheumatoid)
Is there a family history? ☐ YES ☐ NO
☐☐ Osteoporosis / bone disease
☐☐ fractures / broken bones
☐☐ postural deformity (scoliosis etc.)
☐☐ sprain / strain
☐☐ muscle spasm
☐☐ tendinitis / bursitis
☐☐ jaw pain (TMJ)
☐☐ whiplash
☐☐ carpal tunnel syndrome
☐☐ degenerative disk disease

C P Infection
☐☐ hepatitis
☐☐ HIV
☐☐ Tuberculosis
☐☐ herpes
☐☐ skin conditions
list _____

C P Skin
☐☐ Eczema / Dermatitis
☐☐ Psoriasis
☐☐ severe acne
Where? _____

C P Men
☐☐ Prostate Disease

C P Head / Neck
☐☐ history of headaches
☐☐ history of migraines
☐☐ vision problems
☐☐ vision loss
☐☐ ear problems
☐☐ hearing loss

C P Digestive
☐☐ IBS
☐☐ Chrohn's / Colitis
☐☐ GERD (acid reflux)
☐☐ Gall Bladder disorder

C P Other
☐☐ Epilepsy
☐☐ Diabetes *Type* ___ *Onset*_____
☐☐ loss of sensation *Where?*____ _____
☐☐ Cancer *Where?* _____
☐☐ Thyroid disease
☐☐ Depression
☐☐ Pins/ Wires / Joint replacement
Where? _____

C P Women
☐☐ Pregnancy
☐☐ Gynaecological condition
list_____
☐☐ Menopause
☐☐ Painful Menses
☐☐ Fibrotic cysts

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: _____

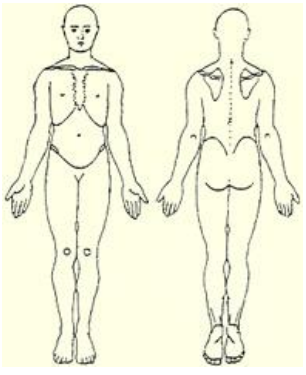
If no, how did you find us?: _____

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: _____