## *Health History Form*

*Name*_____*Address*_____
*Tel home*_____*Bus*_____*City*_____*Postal code*_____
*Date of birth*_____*Occupation*_____*Referred by*_____
*Name and Address of primary Physician*_____
*E-mail address*_____ *Do you consent to e-mail correspondence?* _____

## *Health Information*

*Chief complaint/Where is the pain?*_____*When did it start?*_____
*Describe the pain*_____*Treatment to date*_____
*Aggravating factors*_____*Alleviating factors*_____
*Location/nature of soft tissue/or joint discomfort*_____
*Current Medications and what they treat*_____
*Date of last Medical*_____*Vitamin supplements / remedies*_____
*Other existing Medical conditions*_____
*Operations/ when?* _____
*Have you ever been involved in a motor vehicle accident?*_____*When/ Injuries?*_____
*Any major injuries including broken bones, head injuries, falls, concussions? What/When?*_____
*Ever hospitalized?*_____ *Child/Adult illnesses*_____
*Aims of treatment*_____*General state of Health*_____

### *(√) Please indicate conditions you are experiencing, or have experienced:*

*Are you currently wearing: lumbar support( ) orthotics( ) heel lifts( ) hearing device( )*
*Do you have: artificial limbs( ) pacemaker( ) Harrington rod( ) Other*_____ *pins( ) special equipment( )*

### *Lifestyle*

*Regular exercise( ) Good sleeping patterns( ) Insomnia( ) Healthy eating habits( ) Smoking( ) Pets( ) Family history of Diabetes( ), Cancer( ), Arthritis( ), Heart disease( ), Respiratory ( ), Other( ) Psychotherapy( ) Chiropractic care( ) Physiotherapy( ) Previous Massage( ) Naturopathic Medicine( ) Acupuncture( ) Nutritional( ) Homeopathy( ) Osteopathic Medicine( ) Water intake of 1 liter daily( ) Skin conditions( ) Migraines( )*

### *Health Background*

| | | | |
|---|---|---|---|
| *( )High blood pressure* | *( )Chronic cough* | *( )Diabetes* | *( )Constipation* |
| *( )Low blood pressure* | *( )Shortness of breath* | *( )Epilepsy* | *( )Allergies/reactions*_____ |
| *( )CCHF* | *( )Asthma* | *( )Cancer* | *Anaphylaxis or skin irritation?* |
| *( )Heart attack* | *( )Bronchitis* | *( )Arthritis RA/OA?* | *( )Pregnancy* |
| *( )Stroke/ CVA* | *( )Emphysema* | *( )Hepatitis* | *( )Phlebitis* |
| *( )Pacemaker* | *( )Multiple Sclerosis* | *( )HIV* | *( )Bruise easily* |
| *( )Difficult Digestion* | *( )Loss of sensation* | *( )Tuberculosis* | *( )Menopause* |
| *( )Cuts/Bruises slow to heal* | *( )Chronic fatigue* | *( )joint pain* | *( )Hemophilia* |
| *( )Frequent Headaches* | *( )Vision or hearing loss* | *( )heart disease* | *( )Infectious skin conditions/herpes* |
| *( )Lymphedema* | *( )Gynecological Issues* | | *( )Infectious conditions* |

*An accurate health history is important to ensure that it is safe for you to receive a Massage treatment. If your health changes in the future, please inform the Massage Therapist. All information gathered for this treatment is confidential except as required or allowed by law or except to facilitate assessment and/or treatment.* ***You will be asked to provide written authorization for release of any information.***
*I understand that there is a* ***24-hour cancellation notice;*** *otherwise the full treatment fee may be charged.*

*Date*_____*Signature*_____*Guardian (if under 18)*_____

*Year 2 date/ changes*_____*Signature*_____

*Year 3 date/changes*_____*Signature*_____