Health History

Today's date: M____ D_____ Y _____

The information request below will assist us in treating you safely. Feel free to ask questions about the information being requested. Please note that all information provided will be kept confidential unless allowed or required by law. Your written permission will be required to release any information.		
Name:	Date of Birth: M___ D____ Y _____	
Address:		
City:	Province:	Postal Code:
Home phone:	Work Phone:	Cell Phone:
Email:	Occupation:	
Have you received massage therapy before? ☐ Yes ☐ No		
Did a health care practitioner refer you for massage therapy? ☐ Y ☐ N		
If yes, please provide their name and phone number:		
Family physician name and address:		
Have you received treatment from another health care professional in the past year? ☐ Y ☐ N		
If yes, please provide type of treatment (chiropractic, physio, etc):		
Emergency Contact:	Phone:	
Primary Complaint:		
Injuries:	Date of occurrence:	
Were these injuries sustained as a result of a motor vehicle accident or work injury? ☐ Y ☐ N		
Please list all surgeries and dates:		
Please list all medications and conditions they are treating:		
Did someone other than a health care practitioner refer you? Name:		

For office use:

Notes: _____

_____

_____

Date of Initial Health History: _____

Update 1: _____

Update 2: _____

Update 3: _____

Update 4: _____

Please indicate conditions you are experiencing or have experienced:

Cardiovascular:
□ High Blood Pressure
□ Low Blood Pressure
□ Chronic Congestive Heart Failure
□ Heart attack
□ Heart Disease
□ Heart Palpations
□ Heart Murmur
□ Stroke/CVA
□ Aneurism
□ Blood Clots
□ Raynaud's Disease
□ Phlebitis/Varicose Veins
□ Poor Circulation
□ Pacemaker or Similar Device
□ Angina

Respiratory:
□ Chronic cough
□ Shortness of Breath
□ Bronchitis
□ Asthma
□ Emphysema
□ Pneumonia
□ Tuberculosis
□ Sinus Congestion
□ Sinusitis
Do you smoke? □ Yes □ No

Blood:
□ Anaemia
□ Haemophilia
□ Leukemia
□ Hepatitis A B C

Lifestyle:
Regular Exercise
□ Yes □ Mostly □ No
Drink Plenty of Water
□ Yes □ Mostly □ No
8 Hours of Sleep Nightly
□ Yes □ Mostly □ No
Good Eating Habits
□ Yes □ Mostly □ No

Gastrointestinal:
□ Constipation
□ Diarrhea
□ Gas/Bloating
□ Nausea/Vomiting
□ Irritable Bowel Syndrome
□ Crohn's /Colitis
□ Hernia
□ Ulcers
□ Gall Bladder Problems
□ Liver Problems
□ Kidney Infections
□ Bladder Infections
□ Urination Problems
□ Poor Appetite
□ Excessive Thirst

Skin:
□ Allergies: _____
□ Hypersensitivity: _____
□ Bruises Easily
□ Rashes
□ Eczema
□ Psoriasis
□ Athletes Foot
□ Herpes
□ Warts
□ Skin conditions: _____

Women:
□ Pregnant, Due: _____
□ Infertility
□ Menstrual Concerns/ Pain
□ Menopausal Concerns
□ Endometriosis
□ Fibroids
□ Hysterectomy
□ Vaginal Pain/ Infection

General Health:
□ Good □ Fair □ Poor

Other (please list):

Head/Neck:
□ Headaches
□ Migraines
□ Whiplash
□ Jaw Pain
□ Ear Pain
□ Hearing Problems
□ Vision Problems
□ Vision Loss

Muscle/Joint:
□ Muscle Strain
□ Ligament Sprain
□ Spasms/Cramps
□ Tendinitis
□ Bursitis
□ Fibromyalgia
□ Ankylosing Spondylitis
□ Arthritis circle one: **OA RA**
□ Osteoporosis
□ Herniated Disc
□ Degenerative Discs
□ Joint or Bone Disease
□ Scoliosis
□ Dislocation
□ Fracture

Other Conditions:
□ Diabetes, onset: _____
□ HIV/AIDS
□ Cancer type? _____
□ Multiple Sclerosis
□ Epilepsy
□ Thyroid disorders
□ Lupus
□ Loss of Sensation
Where? _____
□ Insomnia/Fatique
□ Fainting/Dizziness
□ Anxiety/Nervousness
□ Depression
□ Alcohol/Drug Addiction

Is there is a family history of any of the conditions listed above? □ Yes □ No _____
Do you have any internal pins, wires, artificial joints or special equipment? □ Yes □ No
If yes, where? _____