

# Health History

Today's date: D \_\_\_ M \_\_\_ 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: D \_\_\_ M \_\_\_ 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 Palpitations
- 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

Is there 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? \_\_\_\_\_

**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/Fatigue
- Fainting/Dizziness
- Anxiety/Nervousness
- Depression
- Alcohol/Drug Addiction