Health History Form

The information request below will assist us in treating you safely. All information will be kept confidential. Unless required by law, your written permission will be required to release any information.

Name:_____ Date of Birth: _____
Address: _____ City: _____

Province: _____ Postal Code:_____ Phone: (Home)_____ (Cell)_____
Occupation:_____

Email:_____ How did you hear about us?_____

Physician:_____ Phone:_____
Received Registered Massage Therapy Before? [] Yes [] No

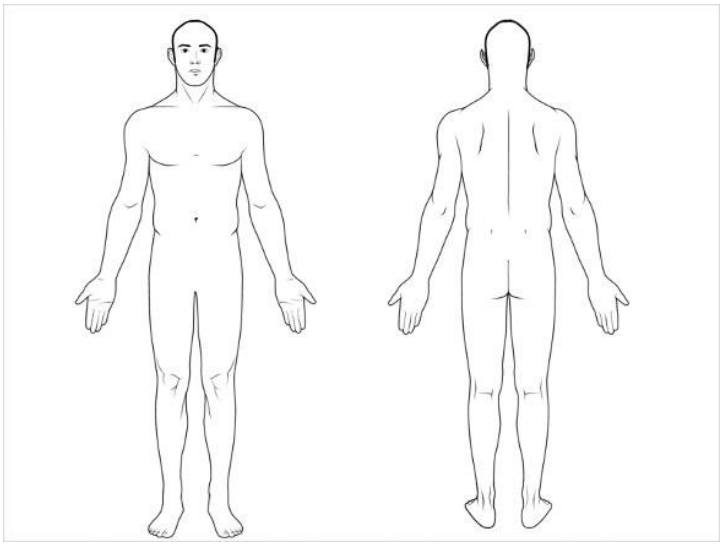
Reason for seeking massage therapy/primary complaint?

_____

_____

_____

Using the diagram please indicate which areas you experience pain/discomfort.



Please check all that apply to you:

Cardiovascular
- [] High blood pressure
- [] Low blood pressure
- [] Chronic congestive heart failure
- [] Heart attack
- [] Heart disease
- [] Stroke / CVA
- [] Phlebitis / Varicose veins
- [] Pacemaker or similar device

Family history of any? [] Yes [] No

Respiratory
- [] Chronic cough
- [] Shortness of breath
- [] Bronchitis
- [] Asthma
- [] Emphysema

Family history of any? [] Yes [] No

Infections
- [] Hepatitis
- [] Skin conditions
- [] TB
- [] HIV
- [] Herpes

Head / Neck
- [] Headaches
- [] Migraines
- [] Vision problems
- [] Vision loss
- [] Ear problems
- [] Hearing loss

Other Conditions
- [] Loss of sensation
  Where? _____
- [] Diabetes
- [] Allergies / Hypersensitivity
  To what?_____
  Type of reaction:_____
- [] Epilepsy
- [] Cancer, where?_____
- [] Skin conditions
  What? _____
- [] Arthritis
- [] Family history of arthritis

Women
- [] Pregnant. Due: _____
- [] Gynecological conditions
  What?_____

Current Medications / conditions treated: _____

Are you currently receiving treatment from another health care professional? Check all that apply.

[] Chiro []Physio []Osteo []Other: _____

Major accidents/surgeries/illnesses/injuries? (Include dates): _____

Do you have any other medical conditions? (e.g. digestive issues, hemophilia, osteoporosis) []Yes [] No

If yes, explain _____

Do you have any internal pins, wires, artificial joints or special equipment? []Yes [] No

If yes, explain _____

Overall, how is your general health?_____

Please read carefully and sign

I attest the information I have provided is true and complete to the best of my knowledge.
Should my health status change, I will inform the therapist prior to treatment.
I understand that I can stop the treatment/session at any point.
24 hours notice is required to cancel or reschedule appointments, or the full charge will apply.

Signature: _____ Date: _____

Updated:

Signature: _____ Date: _____

Signature: _____ Date: _____

Signature: _____ Date: _____