Health History Form

For your information:

An accurate health history is important to ensure that it is safe for you to receive a massage treatment. If your health status changes in the future, please let me know. All information gathered for this treatment is confidential except as required or allowed by law or except to facilitate diagnosis (assessment) or treatment. You will be asked to provide written authorisation for release of any information.

Signature_____ Name_____ Date_____

Address_____

Apt # City Province Postal Code

Telephone res_____ bus_____ cell_____ Email_____

Date of Birth_____ Occupation_____ Last Massage_____

Primary Complaint_____ General Health Status_____

Where did you hear about our clinic?_____

Primary Care Physician _____ Address _____

Health History: Please check the conditions that you currently experience, or have experienced in the past.

	Current	Previous		Current	Previous		Current	Previous
Head/Neck			**Other Conditions**			**Muscles/Joints/Soft Tissue**		
Headache			Difficult Digestion			**Pain/Stiffness**		
Migraine			Constipation			Neck		
Vision Problems			Diabetes, onset:			Shoulders		
Vision Loss			Hypoglycaemia			Upper back		
Ear Problems			Sinus			Mid-back		
Hearing Loss			Insomnia			Low Back		
Respiratory			Cancer			Leg: left/right		
Chronic Cough			Arthritis			Knee: left/right		
Shortness of breath			Family History?			Other:		
Bronchitis			Fibro-myalgia			**Life Style Actions**		
Asthma			Epilepsy			Smoking		
Emphysema			Haemophilia			Alcohol Use Daily/Social		
Cardiovascular			Loss of sensation			Regular Exercise		
High blood pressure			**Skin**			Coffee/Tea 1-3 cups/day		
Low blood pressure			Skin conditions			3+ cups/day		
CCHF			Types:			Mediation/Relaxation/Other		
Heart Attack			**Women**			**Other Health Care**		
Phlebitis			Gynaecological Problems			Chiropractic		
Stroke/CVA			Type:			Physiotherapy		
Pacemaker			Pregnant			Medic Alert Chain/Bracelet		
or similar device			Due Date:			**Allergies**		
Heart disease			Number of Children			Nuts		
Varicose veins			Caesarean section			Food		
Poor circulation						Drug		
Infections						Other		
Hepatitis						**Other Medical Conditions**		
Plantar Warts								
STD								
HIV, AIDS								

Current Medications **Surgery**

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Name	For what Conditions?
_____	_____
_____	_____
_____	_____
_____	_____

Type: _____

_____

Date (dd/mm/yy) _____

Current Symptoms _____

_____

Familial Health Information

Some health problems are hereditary or familial. Information about your family may be helpful in assessing your current condition.

Relationship**:** _____

Illness: _____

_____

Injury including motor vehicle accident

Type: _____

_____

Date (dd/mm/yy/) _____

Current Symptoms: _____

_____

_____

Of Special Note

(pins, wires, plates, artificial joints or limbs, special equipment such as wheelchair, walker, cane dentures, glasses, contact lenses, hearing aid)

_____

_____

Case History Information Updates

Date (dd/mm/yy)	**Signature**
_____	_____
_____	_____
_____	_____
_____	_____

Consent to use your name in instance of sending a referral thank you to another medical professional? ❑ Yes ❑ No

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FOR THERAPIST USE ONLY

Pain Assessment

When did it start? _____

Where is it located? _____

Does it travel for the location? _____(Yes / No)

Where? _____

What makes it better? _____

What makes it worse? _____

What does it feel like? _____

How bad is it? 1 2 3 4 5 6 7 8 9 10

Mild Moderate Severe

Other Notes

_____

_____

_____