HEALTH HISTORY FORM

This health history is important to gather enough information to ensure it is safe for you to receive a massage treatment. Please be accurate and thorough when completing this form and if your health status changes please notify us immediately. All information obtained for this treatment and subsequent visits will be kept in your file and is completely confidential, except as required or allowed by law. You will be asked to sign written authorization for the release of any information.

Client Information:

Name:_____ Date of Birth: ____/____/____(dd/mm/yy) Phone (home): _____
Address: _____ City/Town: _____ Province: _____ Postal Code: _____
Occupation: _____ Phone# (bus):_____ Phone# (cell):_____
email: _____ General Health Status (circle one): **Poor / Fair / Good** Primary Complaint: _____
Physician:_____ Physician Phone Number:_____ Have you ever had massage before? Yes / No
Emergency Contact: _____ Phone Number: _____ Relationship: _____

How did you hear about us? Internet search RMTfind Doctor: _____ Yellowpages
Facebook Friend/Colleague: _____ Other: _____

Would you like to receive our clinic's free monthly e-newsletter? Please circle: YES NO

Medical History: Please indicate the conditions you have or are experiencing currently

RESPIRATORY	Current	Previous
Chronic Cough		
Shortness of Breath		
Bronchitis		
Asthma		
Emphysema		
Do you smoke?		
CARDIOVASCULAR	**Current**	**Previous**
High Blood Pressure		
Low Blood pressure		
High Cholesterol		
Poor Circulation		
C.C.H.F.		
Heart Disease		
Heart Attack		
Stroke/CVA		
Atherosclerosis		
Varicose Veins		
Phlebitis		
Deep Vein Thrombosis		
Hemophilia		
Other:		
DIGESTION	**Current**	**Previous**
Constipation		
Irritable Bowel Syndrome		
Gall Stones		
Kidney Stones		
Urinary Disorders		
Other:		
WOMEN	**Current**	**Previous**
Pregnant: Due Date:___/___/___(dd/mm/yy)		
Menopausal		
Post- Menopausal		
Other:		
Other conditions/diseases		

NERVOUS SYSTEM	Current	Previous
Multiple Sclerosis		
Parkinson's		
Epilepsy		
A.L.S. (Lou Gehrig's)		
Seizures		
Meningitis		
Polio		
Loss of Sensation: _____		
Other:		
SKIN	**Current**	**Previous**
Bruise Easily		
Dermatitis		
Acne		
Warts		
Infectious Skin Condition		
INFECTION	**Current**	**Previous**
HIV/AIDS		
STD: _____		
Hepatitis		
Herpes		
Tuberculosis		
Other:		
OTHER CONDITIONS	**Current**	**Previous**
Diabetes		
Hypoglycemia		
Sinusitis		
Insomnia		
Arthritis		
Osteoporosis		
Fibromyalgia		
Lupus Erythematosus		
Vertigo		
TMJ Dysfunction		
Vision/Hearing Loss		
Allergies/Hypersensitivities:		

Family History: Any information you can provided about your family will help in assessing our condition

RELATIONSHIP	CONDITION
_____	_____
_____	_____
_____	_____
_____	_____

Of Special Note: Please list any special equipment you need to carry out activities (i.e. pins, wires, screws, pacemaker, artificial limbs/joints, wheelchair, cane, walker, dentures, glasses, contact lenses, hearing aid, etc.).

_____
_____
_____
_____

Injury:

Type of Injury	Date	Current Symptoms

Surgery:

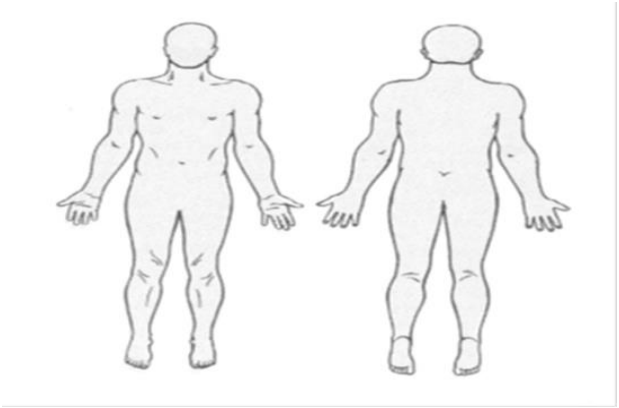
Type of Surgery	Date	Current Symptoms

Current Medications:

NAME	CONDITION IT TREATS
_____	_____
_____	_____
_____	_____
_____	_____

Area of focus: please indicate which areas are causing you pain or stiffness in the chart below and on diagram to right

Head (headache/migraines)	
Neck	
Shoulders: left/right	
Upper back	
Mid-Back	
Lower Back	
Leg: left/right	
Knee: left/right	
Ankle: left/right	
Arm: left/right	
Elbow: left/right	
Wrist: left/right	
Other:	



Other Health Care: Please indicate below any other health care practices you use

Chiropractic		Osteopathy	
Physiotherapy		Chiropody	
Naturopathy		Other:	
Acupuncture			

Lifestyle Activities: Please list any extra-curricular activities/hobbies you are involved in

_____
_____
_____

Thank you for filling out this form. Signature: _____ Date: _____

Health History update:

Date: dd/mm/yy	Signature
_____	_____
_____	_____
_____	_____