

Please Read Carefully

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. Health history will be updated yearly. All information gathered for this treatment is confidential except as required or allowed by law or to facilitate assessment or treatment. You will be asked to provide written authorization for release of any information.

Name: _____ Address: _____

City: _____ Province: _____ Postal Code: _____

Home Phone Number: _____ Birth Date: _____/_____/_____ Age: _____

D D / M M / Y E A R

Who may we thank for referring you to this office? _____ Yellow Pages Advertisement Other
EMAIL _____

General Health Condition _____ Occupation _____

Health History Please indicate any conditions you are experiencing or have experienced.

Respiratory

- chronic cough
- shortness of breath
- bronchitis
- emphysema
- asthma
- other _____

Cardiovascular

- high blood pressure
- low blood pressure
- congestive heart failure
- pacemaker /device
- phlebitis/varicose veins
- heart disease/attack
- stroke / CVA
- other _____

Women

- pregnant
Due: _____

Skin

- skin irritations or conditions (list) _____

Head / Neck

- vision problems / loss
- hearing problems / loss
- sinus problems
- TMJ (jaw problems)
- headaches / migraines
- other _____

Infections

- hepatitis
- skin infection _____
- T B
- HIV
- other _____

Bone

- osteoporosis
- osteomalacia
- rheumatoid arthritis
- spinal deformities (scoliosis)
- other _____

Soft Tissue / Joint Discomfort

(please state the nature of concern)

- neck _____
- shoulders _____
- upper back _____
- mid back _____
- low back _____
- arms _____
- legs _____
- knees _____
- other _____

Other Conditions

- epilepsy
- diabetes/onset _____
- loss of sensation
- neurological diagnosis: _____
- varicose veins
- allergies: _____
- cancer
- other _____

Other medical conditions (i.e. digestive conditions, gynaecological conditions, hemophilia, etc.) _____

Of Special Note (presence of internal pins, wires, artificial joints, special equipment) _____

Injury or Surgery _____ Date _____

_____ Date _____

Medication: _____ Taken For _____
_____ Taken For _____

Family Doctor _____ Telephone: _____

Other Health Practitioners _____ Telephone: _____

_____ Telephone: _____

