Health History Form

Please note all information is kept confidential

Personal Information

Name: ______________________________________ Male/Female D.O.B.______________________

Complete Address: ____

Telephone #'s: HOME______________________ WORK_____________________ CELL_________________

Email address: ____

Occupation: ____

Physician's Name: ____ Telephone # ______________________

Office Location/Address: ____

Medications & Reason for usage: ____

____

____

____

Alternative therapies and last date seen: Chiropractor __________, Physiotherapy _______________

Massage Therapy ___________, Occupational Therapy _________ , Other ___________________________

Current Health Status

Primary Complaint: ____

____

____

Problem Areas:

Please indicate whether you experience Muscle Soreness (MS), Muscle Weakness (MW) or Pain (P)

_____ Spine	_____Shoulder	_____Neck	_____Head
_____Elbow	_____Wrist	_____Hand	_____SI Joint
_____Hip	_____Knee	_____Ankle	_____Foot

Any other areas of discomfort: ____

____

Lifestyle: * Please indicate yes/no/sometimes *

Exercise: _______ Alcohol: ______ Drugs: _____ Smoke: ______ Caffeine: ______ Water: ______

Previous Injuries and Surgeries

* Please list all injuries and surgeries in your lifetime*

Injury/Surgery Date Treatment Received

____

____

____

____

___ Pacemaker ___Cosmetic Implants ____Pins/Plates/Needles (Location:______________________)

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Medical History (Please complete to the best of your knowledge)

Cardiovascular:
___ Hemophilia
___Stroke
___Dizziness
___Chest Pain
___Low blood pressure
___Congestive heart failure
___Buerger's disease
___Raynaud's disease
___Myocardial infarction
___High blood pressure
___ Varicose veins
___Deep vein thrombosis

Respiratory:
___Emphysema
___Asthma
___Cystic Fibrosis
___Bronchitis (Acute/Chronic)
___Chronic Cough
___Breathing difficulty

Neurological:
___ Epilepsy
___ Multiple Sclerosis
___ Parkinson's
___ Cerebral Palsy
___ Sciatica
___Carpal Tunnel Syndrome
___Thoracic Outlet Syndrome
___ Bell's Palsy
___ Neuritis/Neuralgia/Causalgia
___ Other:______________________________

Muscles/Joints:
___ Osteoarthritis
___ Ankylosing Spondylitis
___ Rheumatoid arthritis
___ Osteoporosis
___ Other (please specify)____

Allergies:
___ General allergies *please specify*____
___ Anaphylactic shock

Gastrointestinal:
___ Crohn's disease
___ Ulcerative colitis
___ chronic abdominal discomfort
___ prolonged constipation
___ prolonged diarrhea
___ pelvic inflammatory disease

Other:
___ Diabetes
___ Cancer
___ Hepatitis
___ HIV/AIDS
___ Pregnancy
___ Hearing/vision loss
___ skin irritation (eczema/psoriasis)
___ Fibromyalgia
___ Tuberculosis
___Miscarriages

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<u>Consent to treatment and Cancellation Policies</u>

I, ___________________________, acknowledge that there are possible risk factors and side effects of a massage therapy treatment. Any questions I may have regarding these side effects or risk factors can be discussed openly with the therapist. This consent may be revoked at any time. I have provided the therapist with up to date and accurate medical information and understand that all medical information provided is confidential and may not be released to another health care professional or health insurance company without prior consent.

Registered Massage Therapists are unable to diagnose a complaint/problem. Through testing, a proposed treatment plan is discussed and noted. It is your responsibility as a client to provide appropriate and helpful feedback to the therapist. The client has the right to stop or change the treatment at anytime.

In the interest of mutual respect for each others time, and for other patients of our clinic we have a cancellation policy in place. Cancellations made with less than 24 hours notice will be charged a fee of half the treatment value. I, ____________________ understand that I have been informed of this cancellation policy.

Having reached the age of majority and being legally competent, I provide my full, voluntary informed consent to treatment.

Signature:____________________________________ Date:_________________________

To be completed by parent/guardian if client is under 18 years of age:

I, ______________________ as legal guardian or acting power of attorney of ____________________________ give consent to treatment.

I _____________________ give consent for __________________________ to share such healthcare information with the massage therapist as it may be beneficial for the care of the above-mentioned client.

Parent/Guardian Signature: __________________________ Date: _________________________

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