HEALTH HISTORY FORM

Name:_____ Date: _____

Address:_____ City: _____ Postal Code: _____

Phone: (home)_____ (work)_____ Cell _____

Date of Birth: _____ Weight:_____ Height: _____

Occupation:_____ Sports/Hobbies: _____

Where did you hear about the clinic? _____

What brings you in for a massage today? _____

Do you have insurance coverage for Massage Therapy? ☐ extended health benefit ☐ motor vehicle accident

EMAIL:

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

HEAD/NECK

Current Previous

- ☐ ☐ headaches (type_____)
- ☐ ☐ vision problems
- ☐ ☐ hearing loss
- ☐ ☐ earaches
- ☐ ☐ other_____

RESPIRATORY

Current Previous

- ☐ ☐ chronic cough
- ☐ ☐ pneumonia
- ☐ ☐ shortness of breath
- ☐ ☐ smoking
- ☐ ☐ breathing disorders (ie: asthma, bronchitis, emphysema) type:_____
- ☐ ☐ sinus problems
- ☐ ☐ other_____

SKIN

Current Previous

- ☐ ☐ skin conditions (type_____)
- ☐ ☐ bruise easily
- ☐ ☐ plantar warts
- ☐ ☐ other_____

INFECTIONS

Current Previous

- ☐ ☐ hepatitis
- ☐ ☐ tuberculosis (TB)
- ☐ ☐ HIV, AIDS
- ☐ ☐ other_____

WOMEN

Current Previous

- ☐ ☐ menstrual problems ☐ painful?
- ☐ ☐ gynecological surgery type:_____
- ☐ ☐ pregnant -due date_____
- ☐ ☐ children -#_____
- ☐ ☐ menopausal problems
- ☐ ☐ other_____

CARDIOVASCULAR

Current Previous

- ☐ ☐ high blood pressure
- ☐ ☐ low blood pressure
- ☐ ☐ poor circulation
- ☐ ☐ heart disease / heart attack
- ☐ ☐ pacemaker
- ☐ ☐ chronic congestive heart failure
- ☐ ☐ phlebitis
- ☐ ☐ stroke (paralysis?_____)
- ☐ ☐ varicose veins -Dr. diagnosed? yes/no
- ☐ ☐ other_____

OTHER CONDITIONS

Current Previous

- ☐ ☐ difficult digestion
- ☐ ☐ constipation
- ☐ ☐ Chron's disease or collitis
- ☐ ☐ ulcers (type_____)
- ☐ ☐ diabetes (onset_____ -insulin_____
- ☐ ☐ gallbladder_____
- ☐ ☐ kidney_____
- ☐ ☐ bladder_____
- ☐ ☐ liver_____
- ☐ ☐ allergies (food, hayfever etc.) _____ _____
- ☐ ☐ cancer (type_____) -where_____
- ☐ ☐ epilepsy
- ☐ ☐ multiple sclerosis
- ☐ ☐ parkinson's disease
- ☐ ☐ osteoporosis
- ☐ ☐ fibromyalgia
- ☐ ☐ chronic fatigue syndrome
- ☐ ☐ polio
- ☐ ☐ artificial joints/limbs/pins/wires
- ☐ ☐ use wheelchair/walker/cane etc.
- ☐ ☐ thyroid
- ☐ ☐ other_____

(Please see reverse for additional information)

MEDICATIONS

_____
_____
_____
_____
_____
_____

VITAMIN SUPPLEMENTS

_____
_____
_____
_____
_____

MEDICAL DOCTOR

Name:_____
Phone:_____
Date of last visit:_____
Address: _____
_____

OTHER HEALTHCARE

	Current	Previous
Massage	☐	☐
Chiropractic	☐	☐
Physiotherapy	☐	☐
Exercise	☐	☐
Nutritionist	☐	☐
Naturopath	☐	☐
Homeopath	☐	☐
Psychotherapy	☐	☐
Neurologist	☐	☐

Updated Case History

DATE	CLIENT INITIAL
_____	_____
_____	_____
_____	_____