Health History Form

The information requested below will assist us in treating you safely. Feel free to ask any questions about the information being requested. Please note that all information provided below will be kept confidential unless allowed or required by law. Your written permission will be required to release any information

Name:_____ Home Phone #: ( )_____
Address:_____ Cell #: ( )_____
City:_____ Postal Code:_____
Occupation:_____ Date of Birth (MM/DD/YYYY):_____
Primary Physician:_____ Phone #: ( )_____

E-mail Address:_____

Have you had massage therapy before? ☐ Yes ☐ No
Did your health care practitioner refer you for massage therapy? ☐ Yes ☐ No
If yes, please provide their name and address: _____
Please note you will have an assessment of approximately 15 minutes prior to your massage. Please initial that you've read and understood these terms _____
Please indicate conditions you are experiencing or have experienced:

Cardiovascular
☐ high blood pressure
☐ low blood pressure
☐ chronic congestive heart failure
☐ heart attack
☐ phlebitis/varicose veins
☐ stroke/CVA
☐ pacemaker or similar device
☐ heart disease
☐ other _____
Is there a family history of any of the above? ☐ Yes ☐ No

Respiratory
☐ chronic cough
☐ shortness of breath
☐ bronchitis
☐ asthma
☐ emphysema
Is there a family history of any of the above? ☐ Yes ☐ No

Infections
☐ hepatitis
☐ skin conditions
☐ TB
☐ HIV
☐ herpes

Other Conditions
☐ loss of sensation, where?
_____
☐diabetes, onset: _____
☐ allergies/hypersensitivity to what? _____
Type of reaction: _____
☐ epilepsy
☐ cancer, where?_____
☐ skin conditions, what?
_____
☐ arthritis
Is there a family history of arthritis?
☐ Yes ☐ No

Head/Neck
☐ history of headaches
☐ history of migraines
☐ vision problems
☐ vision loss
☐ ear problems
☐ hearing loss

Digestive Conditions
☐ colitis
☐ Crohn's
☐ IBS
☐ constipation
☐ other _____

Women
☐ pregnant, due:_____
☐ gynaecological conditions, what?
_____

Overall, how is your health?
_____

Current Medications: _____
_____
Condition it treats: : _____
_____

Are you currently receiving treatment from another health care professional? ☐ Yes ☐ No
If yes, for what? _____

Surgery- date: _____
Nature: _____

Injury- date: _____
Nature: _____

Do you have any other medical conditions? (e.g. haemophilia, osteoporosis, mental illness etc)
☐ Yes ☐ No
If yes, what? _____

Do you have any internal pins, wires, artificial joints or special equipment? ☐ Yes ☐ No
What? _____
Where? _____

What is the reason you are seeking massage therapy? Please include the location of any tissue or joint discomfort.
_____
_____

If it is necessary to cancel an appointment, please note we do require 24 hours notice in order to avoid paying for a missed appointment. If an appointment is missed you will be charged according to our policy.
By signing below, I do consent to receive massage therapy treatment.

_____
Signature Date

Blood Pressure:
_____/_____

Treatment procedures

I hereby request and consent to the performance of manual therapy treatments including massage therapy, acupuncture, suction cup therapy, and orthopedic physical assessment. I have the freedom to discuss with the practitioner and or other staff or clinic personnel, the nature and purpose of the treatments and other procedures. I understand that the results are not guaranteed.

I further understand and am informed that, as in all health care there are inherent risks to treatment, including:

- muscle sprains/strains,
- bruising and post treatment soreness.

(Initial) _____

I understand that due to the nature of acupuncture there are increased risk of injury including:

- bruising,
- soreness
- fainting
- bleeding
- infection
- injury to internal organs.

(Initial) _____

I understand that the practitioner will take all necessary steps to limit risks during my treatment. I do not expect the practitioner to be able to anticipate and explain all risks and complications. I wish to rely on the practitioner to exercise judgment during the course of the procedure, which the practitioner feels at the time, based upon the facts then known, is in my best interests.

I give my express permission for the therapists to contact me for the purposes of following post treatment and informing me of future clinic activities.
(INTITAL) _____

I have read the above consent. I also had an opportunity to ask questions about its content, and by signing below I agree to the above-mentioned treatment procedures. I am aware that I can withdraw my consent, and stop the treatment at any time. I intend this consent form to cover the entire course of treatment for my present condition.

_____ _____

Patients Name **Patients Signature**

_____

Date