CONFIDENTIAL HEALTH HISTORY INTAKE FORM

PERSONAL INFORMATION Date: _____

Last Name	First Name	_____/_____/_____ D.O.B. (dd/mm/yyyy)	☐ Male ☐ Female
Mailing Address	City	Province	Postal Code
Phone (Home)	Phone (Cell)	Email Address	
Occupation	Emergency Contact Name	Emergency Contact Phone	
Doctor's Name	Date of Last Doctor's Visit	Doctor's City / Phone	

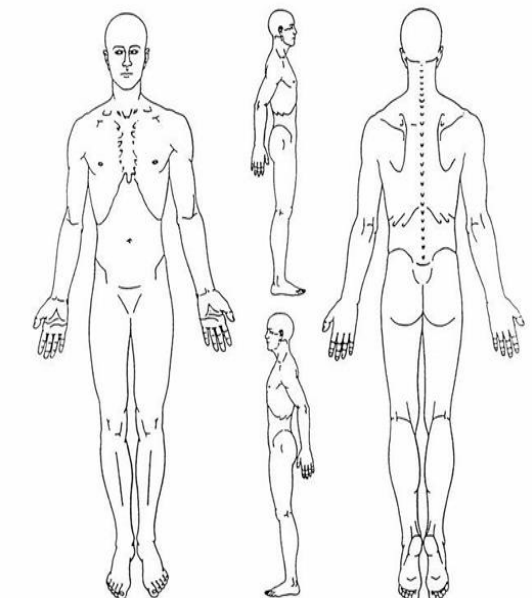
Have you received massage therapy before? ☐ Yes ☐ No

CURRENT HEALTH STATUS

What is the primary reason you are seeking massage therapy?

_____

(Please indicate all locations of your pain or discomfort on the diagram)



When did your symptoms first begin?_____

How long has the condition been bothering you? _____

What aggravates your symptoms?_____

What relieves your symptoms?_____

What activities of daily living are now difficult?_____

Are you currently seeking treatment from other health care professionals?
If yes, for what?

- ☐ Medical Doctor:_____
- ☐ Physiotherapist: _____
- ☐ Chiropractor: _____
- ☐ Naturopath: _____
- ☐ Acupuncture: _____

Rate pain level: 1 low – 10 high _____

Circle all that apply in describing your pain:

Achy Stiff Dull Numb Tingling Sharp Shooting

General health level: 1 low – 10 optimal _____

Daily stress level: 1 low – 10 high _____

Are there any other conditions you would like to discuss?_____

List of Medications / Supplements:

Name:	Reason for use:	Notes:

MEDICAL HISTORY

Please indicate which of the following you are currently experiencing, or have experienced:

CARDIOVASCULAR
- ☐ Stroke/ CVA
- ☐ High Blood Pressure
- ☐ Low Blood Pressure
- ☐ Circulatory Disorders
- ☐ Varicose Veins
- ☐ Pacemaker
- ☐ Phlebitis
- ☐ Heart Disease
- ☐ Chronic Congestive Heart Failure
- ☐ Myocardial Infarction
- ☐ Other _____

RESPIRATORY
- ☐ Emphysema
- ☐ Asthma
- ☐ Chronic Cough
- ☐ Bronchitis
- ☐ Breathing Difficulty
- ☐ Lung Disorder

NEUROLOGICAL
- ☐ Epilepsy
- ☐ Multiple Sclerosis
- ☐ Loss of Sensation
- ☐ Numbness
- ☐ Neuritis
- ☐ Other _____

DIGESTIVE & URINARY
- ☐ Constipation
- ☐ Frequent Urination
- ☐ Diarrhea
- ☐ Irritable Bowel Syndrome
- ☐ Ulcerative Colitis
- ☐ Pelvic Inflammatory Disease
- ☐ Heartburn
- ☐ Gas and Bloating
- ☐ Liver/Gall Bladder
- ☐ Kidney/Bladder
- ☐ How many bowel movements per day: ____ or per week: _____
- ☐ Other _____

FEMALE
- ☐ Menstrual Problems
- ☐ Pregnant: Week: ____
- ☐ Menopausal Problems
- ☐ Endometriosis
- ☐ C-section
- ☐ Other _____

MALE
- ☐ Haemorrhoids
- ☐ Prostate Problems
- ☐ Hernias
- ☐ Other _____

SKIN
- ☐ Easily Bruise
- ☐ Eczema/Psoriasis
- ☐ Rash
- ☐ Cold Sores/Warts
- ☐ Herpes
- ☐ Athletes Foot
- ☐ Loss of Sensation
- ☐ Skin Conditions _____

ALERGIES
- ☐ No
- ☐ Yes

List: _____

_____

HEAD & NECK
- ☐ Headache
- ☐ Migraine
- ☐ Visual Disturbances
- ☐ Earaches
- ☐ Hearing Problems
- ☐ Teeth/Jaw Pain
- ☐ Locked Jaw
- ☐ Sinus Pain
- ☐ Dizziness/Vertigo
- ☐ Whiplash/ Injury _____ (Date of accident)
- ☐ Other _____

MUSCLES & BONES
- ☐ Scoliosis
- ☐ Osteoporosis
- ☐ Carpal Tunnel Syndrome
- ☐ Bone/Joint Disorder _____
- ☐ Fractured Bone _____
- ☐ Arthritis _____
- ☐ Tendonitis _____
- ☐ Bursitis _____

OTHER
- ☐ Diabetes Type: ____
- ☐ Cancer Type: _____
- ☐ HIV/AIDS
- ☐ Tuberculosis
- ☐ Hepatitis
- ☐ Insomnia
- ☐ Chronic Fatigue Syndrome
- ☐ Seasonal Affective Disorder
- ☐ Depression
- ☐ Fibromyalgia
- ☐ Haemophilia
- ☐ Other _____

Injury

Nature: Date:

_____

_____

Surgery

Nature: Date:

_____

_____

Do you have **internal pins, wires, artificial joints** or special equipment?
- ☐ No
- ☐ Yes

What? _____

Where? _____

LIFESTYLE CHECKLIST
- ☐ Exercise regularly _____x/week
- ☐ Consume caffeine _____x/week
- ☐ Consume alcohol _____x/week
- ☐ Smoke _____x/week

I, _____, declare that all above information is correct to the best of my knowledge, and if it should change (including medications, treatments, and diagnoses) it is my responsibility to notify the therapist of these changes at the next scheduled appointment. I understand there is a risk to any treatment received, and my therapist will answer any and all questions I have relating to my treatment.

Your written consent will be required to release any of your confidential health history information.

Date:_____

Signature:_____

Date of initial Health History: _____	Initial Blood Pressure: _____
Update 1: _____	Update 1: _____
Update 2: _____	Update 2: _____