BeachChiropractic & Wellness Centre

Massage Therapy Health History Form

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 confidentially unless allowed or required by law. Your written permission will be required to release any information.

Name:_____ Phone #:_____

Address:_____

Occupation: _____ Date of Birth: _____

Have you received massage therapy before? □ Yes □ No Email address: _____

Did a health care practitioner refer you for massage therapy? □ Yes □ No

If yes, please provide their name and address: _____ Do you have Extended □ Yes

_____ Healthcare Benefits? □ No

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

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

Women

- □ Pregnant, due: _____
- □ Gynaecological conditions, what? _____

Overall, how is your general health? _____

Primary Care Physician: _____

Address: _____

_____

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. digestive conditions, haemophilia, osteoporosis, mental illness) □ Yes □ No

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:

_____

_____

Notes:

Date of initial Health History: _____

Update 1 _____

Update 2 _____

Update 3 _____

Update 4 _____