Health History Form

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

Name: (please print) ____________________ (first & last) **Date of Birth:** ____________________ (mm/dd/yr)

Occupation: ____________________ Have you received massage therapy before? ❒Yes ❒No

Did a health care practitioner refer you for massage therapy? ❒ Yes ❒ No If yes, who? ____________________

If no, please indicate how you heard about the clinic. ❒ internet ❒ yellow pages ❒ friend/family/co-worker ❒ social media ❒ flyer ❒ other: ____________________

Please indicate conditions you are experiencing or have experienced:

Cardiovascular Infections
❒ high blood pressure
❒ low blood pressure
❒ chronic congestive heart failure
❒ heart attack
❒ phlebitis/varicose veins
❒ stroke/CVA
❒ pacemaker or similar device
❒ heart disease

Respiratory
❒ chronic cough
❒ shortness of breath
❒ bronchitis
❒ asthma
❒ emphysema

Soft tissue/joint discomfort
❒ neck ❒ low back
❒ mid back ❒ upper back
❒ arms L/R ❒ legs L/R
❒ knees L/R ❒ shoulders L/R
Other: ____________________

Infections
❒ hepatitis ❒ TB
❒ skin conditions ❒ herpes

Other Conditions
❒ loss of sensation, where? ____________________
❒ diabetes, onset: ____________________
❒ allergies/hypersensitivity to what? ____________________
❒ epilepsy
❒ cancer, where? ____________________
❒ skin conditions, what? ____________________
❒ arthritis

Other Health Care:
❒ chiropractic ❒ naturopath
❒ physiotherapy ❒ osteopathy
❒ acupuncture ❒ reflexology
Other ____________________

Head/Neck
❒ history of headaches
❒ history of migraines
❒ vision problems/loss
❒ ear problems/hearing loss
❒ concussions #__________

Overall, how is your general health? ____________________

Primary Care Physician: ____________________

Do you currently get a sound 8 hours sleep per night? ____________________

Women:
❒ pregnant, due: ____________________
❒ gynecological conditions, what? ____________________

What is your primary complaint: ____________________

Current Medications: ____________________
Condition it treats: ____________________

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Condition it treats: ____________________

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Condition it treats: ____________________

Surgery – date ____________________
nature: ____________________

Surgery – date ____________________
nature: ____________________

Injury – date____________________
nature: ____________________

Injury – date____________________
nature: ____________________

Do you have any internal pins, wire, artificial joints or special equipment? Yes ❒ No ❒
what?__________ where?__________

Do you have any other medical conditions? (eg. Digestive conditions, hemophilia, osteoporosis, mental illness)
Yes ❒ No ❒ Explain ____________________

NOTES (for therapists use)

Date of initial health history ____________________
Update 1 __________ Update 2 __________
Update 3 __________ Update 4 __________

Personal Pain History Form

Name: ________________________________ **Date:** ____________________

The following is a confidential questionnaire which will help us determine the best possible course of treatment for you. Please take your time and complete the information accurately. Thank you!

PLEASE PRINT

What is your chief complaint at this time? ____________________

Where do you feel the pain/symptoms? ____________________

When did it start? ____________________
(include month and year and day if known)

How did it start? ____________________
(type of injury)

What makes the pain better? ❒ Ice ❒ Heat ❒ Rest ❒ Activity ❒ Other ____________________

How would you describe the pain? ❒ Dull ❒ Ache ❒ Burning ❒ Stabbing ❒ Other ____________________

At what time of the day and/or week is your pain worse? ____________________

Does the pain radiate to other areas of the body? If so, where? ____________________

On a scale of 0 to 10, (0 being no pain and 10 being worst pain) what would you rate your pain?

Now: ____/10 At Worst: ____/10 At Best: ____/10

Most of the time: ____/10 Morning: ____/10 Night: ____/10

Have you had this problem in the past? ____________________ If so, how often? ____________________

Does the pain/symptoms stop you from doing any task or movement? Is there a movement that makes the pain worse? (please describe)

____

____

Is your pain the result of a motor vehicle accident? ____________________

If so, have you filed with your insurance adjudicator? ____________________

Is your pain the result of a work related injury? ____________________

If so, have you filed a worker's compensation claim? ____________________