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HEALTH HISTORY FORM

Information recorded below is kept confidentially unless allowed/required by law. Your written permission will be required to release any information.

Name: _____ Occupation: _____
Address: _____ MD: _____
City : _____ Post Code: _____ MD Address: _____
Phone: H _____ W_____ C_____ Chiropractor: _____
Email: _____ Other Therapy: _____
Birth Date: _____ Referred by: _____

	Y	N	PLEASE PROVIDE DETAILS
Do you have Extended Health Care benefits for massage therapy?	☐	☐	
Do you have any infections or infectious conditions?	☐	☐	
Do you have internal pins, wires, devices, or artificial joints (describe)?	☐	☐	_____

MAJOR COMPLAINT: (onset & location of pain)

_____
_____
_____

SURGERY / INJURIES / ACCIDENTS: (when, what)

_____
_____
_____

MEDICATIONS: (Name / Prescribed for?) _____

MUSCLES / JOINTS:
- ☐ Joint/Muscle Pain (where?)
- ☐ Rheumatoid Arthritis
- ☐ Osteoarthritis
- ☐ Fibromyalgia
- ☐ Other

RESPIRATORY:
- ☐ Asthma
- ☐ Emphysema
- ☐ Other

DIGESTIVE / URO-GENITAL:
- ☐ Liver/Gall Bladder
- ☐ Kidney/Bladder
- ☐ Nausea
- ☐ Other

NEUROLOGICAL:
- ☐ Sensory Loss
- ☐ Paralysis/Motor Loss
- ☐ Entrapment Syndromes
- ☐ Other

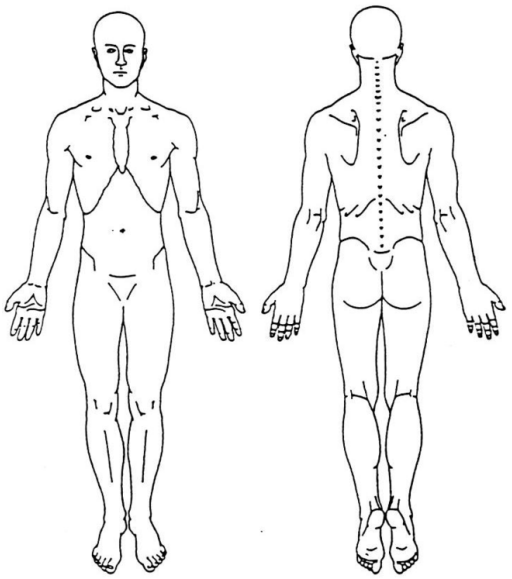
HEAD / NECK:
- ☐ Headaches (Migraine)
- ☐ Headaches (Tension)
- ☐ Neck Pain
- ☐ Sinus Trouble
- ☐ Dizziness

REPRODUCTIVE:
- ☐ Hysterectomy
- ☐ PMS
- ☐ Other

CIRCULATORY:
- ☐ Recent Stroke/Heart Attack
- ☐ High Blood Pressure
- ☐ Diabetes
- ☐ Other

OTHER CONDITIONS:
- ☐ Immune Disorders
- ☐ Thyroid
- ☐ Allergies
- ☐ Other

Please mark areas of pain on these figures:



I understand that 24 hours notice are required for appointment cancellations, and that there is a fee for late cancellations and missed appointments. I also understand I may give feedback regarding depth of pressure and any discomfort I may feel during treatment, and that I (or the therapist) may terminate treatment if comfort levels become unacceptable. I understand I need only remove what clothing I wish, and that I may be treated fully clothed if I wish. My signature below constitutes consent to treatment, and consent for this personal information to be kept according to PIPEDA (Personal Information Protection & Electronic Documents Act.

DATE: _____ SIGNATURE: _____