**Health History Form**

|  |  |
| --- | --- |
| Full name: Click here to enter text. | |
| Birth date: Click here to enter text. | Male/Female: Click here to enter text. |
| Email address: Click here to enter text. | |
| Street address: Click here to enter text. | |
| City/Prov/PC: Click here to enter text. | |
| Contact Phone: (902) Click here to enter text.  Other: (902) Click here to enter text. | work/home/cell: Click here to enter text.  work/home/cell: Click here to enter text. |
| Occupation: Click here to enter text. | |
| Emergency contact name: Click here to enter text.  Emergency contact’s phone: (902) Click here to enter text. | |
| Family Physician: Click here to enter text. | |
| Address: Click here to enter text. | |
| Phone: (902) Click here to enter text. | |

**If this is a doctor’s referral do I have your consent to contact them and share your treatment information with them? Yes No**

How did you hear about me?

Click here to enter text.

Name of person referred by:

Click here to enter text.

**Therapy treatment**

Have you had massage therapy before? **Yes No**

If yes, approximate date of last treatment:

Click here to enter text.

Are you currently seeing another healthcare professional for treatment? **Yes No**

If yes, name of professional:

Click here to enter text.

**Have you taken an anti-inflammatory or pain killer today?** (Tylenol, Aleve, Aspirin, Advil, etc.)

Click here to enter text.

**Yes No If yes, at what time:**

**Please list any current medications and what they are for, below:**

|  |  |
| --- | --- |
| Click here to enter text. | Click here to enter text. |
| Click here to enter text. | Click here to enter text. |
| Click here to enter text. | Click here to enter text. |
| Click here to enter text. | Click here to enter text. |
| Click here to enter text. | Click here to enter text. |
| Click here to enter text. | Click here to enter text. |

**What prompted your visit today?** (check all that apply)

|  |  |  |  |
| --- | --- | --- | --- |
|  | Personal health |  | Injury/Pain |
|  | Stress |  | Other (explain): Click here to enter text. |

**Are you affected by any of the following conditions?** (check all that apply)

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
|  | Allergies or Hypersensitivity reactions |  | Gastro-intestinal or Digestive Ailments | |  | Pregnancy  Due date: |
|  | Arthritis/Bursitis |  | Headaches/Migraines | |  | Numbness or Tingling sensation |
|  | Asthma/Emphysema |  | Hearing or Vision loss | |  | Osteoporosis |
|  | Athlete’s Foot |  | Heart disease | |  | Pacemaker or similar device |
|  | Bronchitis/Chronic cough |  | Hepatitis A, B or C | |  | Poor circulation |
|  | Cancer |  | Herpes | |  | Psoriasis/Eczema |
|  | Concussion |  | High Cholesterol | |  | Shingles |
|  | Crohn’s/Colitis |  | High or Low Blood pressure | |  | Skin irritation/rashes |
|  | Depression |  | HIV/Aids | |  | Sports injury |
|  | Diabetes |  | Infections | |  | Stroke/Aneurism |
|  | Edema/Swelling |  | Infectious Disease | |  | Varicose Veins/Phlebitis |
|  | Epilepsy |  | Metal plates/Screws/Implants | |  | Viruses (cold, flu) |
|  | Fibromyalgia |  | Neck or Spine injury | |  | Warts or Plantar warts |
| Family History of: Click here to enter text. | | | | Other: Click here to enter text. | | |

**Are you receiving any medical care for any conditions not listed above? Yes No**

|  |  |  |
| --- | --- | --- |
| Explain: Click here to enter text. |  |  |

**Have you been in an accident or had an injury or surgery I should know about? Yes No**

|  |  |  |
| --- | --- | --- |
| Explain and date: Click here to enter text. |  |  |

**What is the primary concern or physical complaint which has brought you in today?**

|  |
| --- |
| Click here to enter text. |

**In what areas are you currently experiencing discomfort?**

|  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- |
|  | **Head** |  | **Neck** |  | **Knees** |  | **Joint Pain:** |
|  | **Jaw** |  | **Hands** |  | **Calves** |  | **Shoulders** |
|  | **Arms** |  | **Hips** |  | **Glutes** |  | **Elbows/Wrists** |
|  | **Shoulders** |  | **Legs** |  | **Feet** |  | **Hips** |
|  | **Upper back** |  | **Middle back** |  | **Lower back** |  | **Knees/Ankles** |

Please read and sign:

• I attest that the information I have provided is true and complete to the best of my knowledge.

• I understand the information I have provided on this form is confidential and will not be released without my written consent.

• I understand that the therapist can end treatment at anytime due to inappropriate behaviour.

• I understand that all sessions include a pre-health assessment and change time.

**Note:** (There will be a printed copy of your completed form for you to sign and date at your first appointment)

**Signature:** Click here to enter text. **Date:** Click here to enter text.