your massage therapy clinic

Michèle McBeigh, Registered Massage Therapist

Health History Form

An accurate health history is important to ensure that it is safe for you to receive treatment. If your health status changes in the future, please let us know. All information gathered for this treatment is protected and confidential except as required or allowed by law. Your written permission will be required to release any information. You have the right to access personal information in your clinic file.

Full Name: ______________________________ Date: ____________________

Address: ______________________________ Tel. res. ____________________

Email: ______________________________ Tel. bus. ____________________

Occupation: ______________________________ Date of birth: ____________________

Referred by: ______________________ Physician: ________________________

Health History: Please indicate conditions you are experiencing or have experienced:

Medications

____

____

____

____

____

Respiratory

- ☐ Chronic cough
- ☐ Shortness of breath
- ☐ Bronchitis
- ☐ Asthma
- ☐ Emphysema

Cardiovascular

- ☐ High blood pressure
- ☐ Low blood pressure
- ☐ Chronic congestive heart failure
- ☐ Heart attack
- ☐ Phlebitis
- ☐ Stroke/CVA
- ☐ Pacemaker or similar device

Other Conditions

- ☐ Loss of sensation
- ☐ Diabetes (onset:_________)
- ☐ Allergies (ie. Anaphylaxis or skin irritations)
- ☐ Epilepsy
- ☐ Cancer
- ☐ Arthritis (osteo/rheumatoid)
- ☐ Kidney disease
- ☐ Digestive problems
- ☐ Crohn's disease
- ☐ Other ____________________

Head/Neck

- ☐ Vision problems
- ☐ Vision loss
- ☐ Ear problems
- ☐ Hearing loss

Infections

- ☐ Hepatitis
- ☐ Skin conditions
- ☐ TB
- ☐ HIV

Soft tissue/joint discomfort and its nature

- ☐ Neck ________________
- ☐ Low back________________
- ☐ Mid back________________
- ☐ Upper back_____________
- ☐ Shoulders ______________
- ☐ Arms _________________
- ☐ Legs __________________
- ☐ Knees _________________
- ☐ Other _________________

Skin

- ☐ Skin conditions

____

Women

- ☐ Pregnant

Due date: ________________

- ☐ Menstrual problems
- ☐ Gynaecological conditions

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Primary Complaint: ____

Are you receiving care from any of the following: (please circle)

Physiotherapist   Chiropractor   Naturopath   other: ______________

Have you had surgery in the past?   □ Yes   □ No

If yes, for what? ____________________

Have you had fractures/sprains in the past?   □ Yes   □ No

If yes, for what? _____________________________

Do you have any internal pins, wires, artificial joints or special equipment?

□ Yes   □ No   If yes, what and where? ____

Have you had serious illnesses in the past?   □ Yes   □ No

If yes, for what? ___________________

Have you had any of the following regarding your current condition:

□ Physician's examination
□ X-ray
□ Other diagnosis tests _______________________________

Patient's signature (or Guardian): _____________________________________