

Massage Therapy

Health History Form:

Name: _____ Date: _____

Address: _____

City _____ Province _____ Postal Code: _____

Telephone: Home: (____) _____ Business: (____) _____ Cell (____) _____

Date of Birth: _____ (DD/MM/YY) Occupation: _____

Doctor's Name: _____ Address: _____

Other Health Practitioner (s): _____

Main Reason For Coming: _____

What have you tried for relief? Heat ___ Cold ___ Exercise ___ Other _____

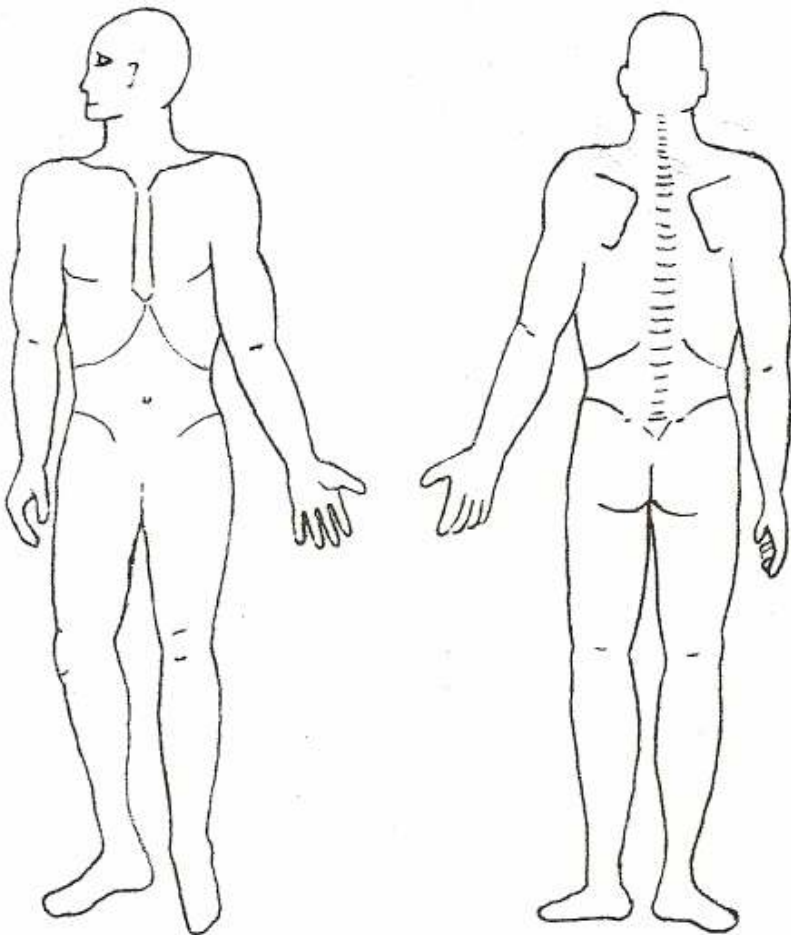
How were you referred to this Clinic? _____

Email Address: _____

Please check this box if you would like to receive a monthly newsletter:

Please indicate on the picture where you feel pain:

'S' = Stiffness 'X' = Pain 'N' = Numbness and/or tingling



Which areas provide discomfort or pain?

- Neck
- Upper Back
- Mid Back
- Lower Back
- Arm (circle if right, left or both)
 - Right Left Both
- Shoulder/Elbow/Wrist (circle if right, left or both)
 - Right Left Both
- Leg (circle if right, left or both)
 - Right Left Both
- Hip/Knee/Ankle (circle if right, left or both)
 - Right Left Both
- Other _____

Please complete the reverse side of this form:



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Please check the box if it currently or previously applies to you:

Head/Neck:

- Headaches
- Migraines ()aura
- Vision/hearing problems
- Vision/hearing loss
- Earaches
- Herniated disk

Skin:

- Skin conditions (oily, dry, other)
- Bruise easily
- Plantar warts
- Rashes
- Loss of sensation
- Eczema or psoriasis

Cardiovascular:

- High blood pressure
- Low blood pressure
- Poor circulation
- Heart disease
- Phlebitis
- Varicose veins
- Deep vein thrombosis
- Congestive heart failure
- Stroke/CVA
- Heart Attack

Respiratory:

- Asthma
- Chronic Cough
- Shortness of breath
- Bronchitis
- Emphysema
- Allergies

Digestive/Urinary:

- Constipation/Diarrhea
- Liver/gall bladder problems
- Kidney/bladder problems
- Crohnes diseases/Colitis/IBS
- Ulcers

Other Conditions:

- Hemophilia
- Diabetes – type _____
- Epilepsy
- Cancer – where: _____
- Arthritis ()RA () OA
- Fibromyalgia
- Chronic fatigue syndrome
- Osteoporosis
- Scoliosis
- Polio, post polio syndrome

Infectious Conditions:

- Tuberculosis
- AIDS/HIV
- Hepatitis: type _____
- Herpes
- Infectious Skin Conditions

Female:

- Menstrual problems
Heavy ___ Scant ___
Pain ___
- Pregnancy
Due: _____
- Menopausal problems

Surgical Procedures:

- Pins/wires
- Artificial joints/limbs
- Other surgery

Medications:

What? _____
How Long? _____
Condition it treats? _____

Do you have or have had any of the following? If it is previous, please mark the month and year:

Motor Vehicle Accident: _____
Muscle/Ligament Sprain or Strain: _____ Fracture/Break: _____
Tendonitis/Bursitis/Carpel Tunnel/Thoracic Outlet Syndrome: _____
Any additional information?: _____

Please Note: You will be charged for any missed appointments, or if canceled without 24 hours notice.

Patient Consent to Treatment:

I understand that I have the right to ask questions about my treatment. If at any time I feel uncomfortable, I can ask the Therapist to stop or to clarify anything regarding the treatment. I am aware that Waterloo North Chiropractic & Massage is keeping the personal information outlined for the reasons disclosed. I have been informed that my file may be examined in a peer review to ensure quality of care I receive. Finally, I am aware that the members of staff at Waterloo North Chiropractic & Massage may access this information. I give my consent for this information to be collected and disclosed as outlined to me.

Patient Signature: _____ Date: _____

Initial: _____ Date: _____
Initial: _____ Date: _____

Initial: _____ Date: _____
Initial: _____ Date: _____

Initial: _____ Date: _____
Initial: _____ Date: _____

