

# HEALTH HISTORY FORM

Name: \_\_\_\_\_ Date: \_\_\_\_\_

Address: \_\_\_\_\_

City, Province \_\_\_\_\_ Postal Code: \_\_\_\_\_

Home Phone: \_\_\_\_\_ Business Phone: \_\_\_\_\_

M ( ) / F ( ) Date of Birth (D/M/Y) \_\_\_\_/\_\_\_\_/\_\_\_\_

Primary Physician: \_\_\_\_\_ Phone: \_\_\_\_\_

Occupation: \_\_\_\_\_

Current Medications: \_\_\_\_\_

Present Complaint(s): \_\_\_\_\_

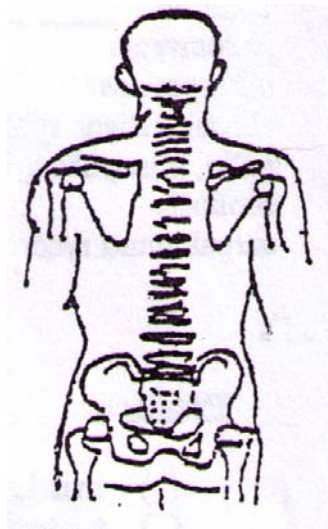
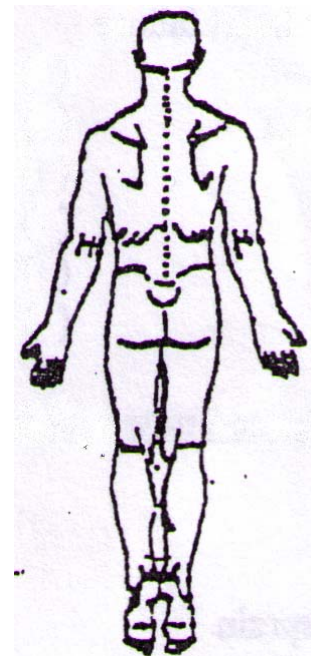
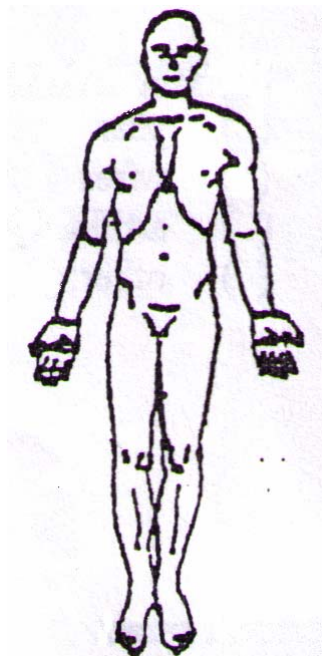
Expectations: \_\_\_\_\_

Have you had any previous treatment for the above complaint by a Massage Therapist? \_\_\_\_ Chiropractor? \_\_\_\_ Physiotherapist? \_\_\_\_ Doctor? \_\_\_\_ Other? \_\_\_\_\_

Are on taking any medication? \_\_\_\_\_

If so, which ones and to treat what? \_\_\_\_\_

Indicate "X" for muscle stiffness or aching / "O" for numbness / "/" for pins and needles



(to be taken by therapist)  
**BLOOD PRESSURE**  
\_\_\_\_\_  
DATE: \_\_\_\_\_

**HEAD/NECK**

- Current Previous  
  headache  
  migraine ( ) with aura  
  vision problems  
  herniated disc  
  hearing loss

**RESPIRATORY**

- Current Previous  
  asthma  
  chronic cough  
  shortness of breath  
  bronchitis  
  emphysema  
  fever or flu

**INFECTIOUS DISEASE**

- Tuberculosis  
 AIDS/HIV  
 Hepatitis  
 type: \_\_\_\_\_  
 Infectious skin condition  
 location: \_\_\_\_\_  
 Herpes

**SKIN**

- Current Previous  
  skin conditions  
  bruise easily  
  rashes  
  eczema/psoriasis  
 Where? \_\_\_\_\_  
  loss of sensation  
 Where? \_\_\_\_\_

**DIVESTIVE/URINARY**

- Current Previous  
  constipation  
  liver/gall bladder  
  kidney/bladder  
  Chrono's disease/ Colitis  
  diabetes,  
 type: \_\_\_\_\_  
  ulcers

**FEMALE**

- Current Previous  
  menstrual problems  
  painful  heavy  
  scant  
  pregnancy-due \_\_\_\_\_  
  menopausal problems  
 type: \_\_\_\_\_

**CARDIOVASCULAR**

- Current Previous  
  high blood pressure  
  low blood pressure  
  poor circulation  
  heart disease  
  shortness of breath  
  phlebitis  
  varicose veins  
  congestive heart failure  
  stroke  
  myocardial infarction  
  pacemaker  
  aneurysm

**OTHER CONDITIONS**

- Current Present  
  hemophilia  
  epilepsy  
  frequent colds  
  cancer  
 location: \_\_\_\_\_  
  arthritis RA ( ) OA ( )  
 location: \_\_\_\_\_  
  fibromyalgia  
  osteoporosis  
  polio, post-polio syndrome  
  scoliosis  
  carpal tunnel syndrome  
  loss of sensation, where \_\_\_\_\_

**SURGICAL IMPLANTS**

- pins  
 wires  
 artificial joints/limbs  
 other: \_\_\_\_\_  
 other surgery, date: \_\_\_\_\_  
 nature: \_\_\_\_\_

**CURRENT**

- muscle strain / ligament strain  
 tendonitis / fibrositis / bursitis  
 fracture, location \_\_\_\_\_  
 whiplash, when? \_\_\_\_\_  
 other, specify: \_\_\_\_\_

**PREVIOUS**

- muscle strain / ligament sprain  
 tendonitis / fibrositis / bursitis  
 fracture, location \_\_\_\_\_  
 whiplash, when? \_\_\_\_\_  
 other, specify: \_\_\_\_\_

Any additional information you would like to provide \_\_\_\_\_

List any family history of health conditions \_\_\_\_\_

**By signing this Case History Form I consent to treatment and ensure that all the above information is accurate.**

SIGNATURE: \_\_\_\_\_ DATE: \_\_\_\_\_