# CONFIDENTIAL HEALTH HISTORY INTAKE FORM

**PERSONAL INFORMATION** Date:

_____

_____ _____ _____/_____/_____ ☐ Male ☐ Female
Last Name First Name D.O.B. (dd/mm/yyyy)

_____ _____ _____ _____
Mailing Address City Province Postal Code

_____ _____ _____
Phone (Home) Phone (Cell) Email Address

_____ _____ _____
Occupation Emergency Contact Name Emergency Contact Phone

_____ _____ _____
Doctor's Name Date of Last Doctor's Visit Doctor's City / Phone

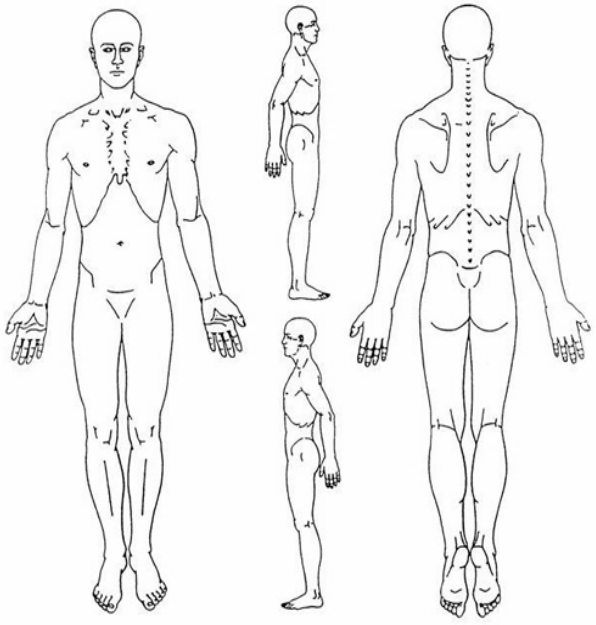
Have you received massage therapy before? ☐ Yes ☐ No

## CURRENT HEALTH STATUS

**What is the primary reason you are seeking massage therapy?**
(Please indicate all locations of your pain or discomfort on the diagram)

_____

_____



**Circle all that apply in describing your pain sensation:**

Achy Stiff Dull Numb Tingling
Sharp Shooting Throbbing Burning

**This discomfort is affecting your:**

Work activity / sport home life
sleep

**Rate pain level**: 1 low – 10 high _____

**General health level**: 1 low – 10 optimal

**Current Medications / Supplements:**

| Name: | Reason for use: |
|---|---|
| | |
| | |
| | |
| | |
| | |

**Are you currently seeking treatment from other health care professionals?**

**If yes, for what?**

_____
☐ Medical Doctor

_____
☐ Physiotherapist

_____
☐ Chiropractor

_____
☐ Naturopath

_____
☐ Acupuncture

## MEDICAL HISTORY

Please indicate which of the following you are currently experiencing, or have experienced:

### CARDIOVASCULAR
- ☐ Stroke/ CVA
- ☐ High Blood Pressure
- ☐ Low Blood Pressure
- ☐ Circulatory Disorders
- ☐ Varicose Veins
- ☐ Pacemaker
- ☐ Phlebitis
- ☐ Heart Disease
- ☐ Chronic Congestive Heart Failure
- ☐ Myocardial Infarction
- ☐ Other

_____

### RESPIRATORY
- ☐ Emphysema
- ☐ Asthma
- ☐ Chronic Cough
- ☐ Bronchitis
- ☐ Breathing Difficulty
- ☐ Lung Disorder

### NEUROLOGICAL
- ☐ Epilepsy
- ☐ Multiple Sclerosis
- ☐ Loss of Sensation
- ☐ Numbness
- ☐ Neuritis
- ☐ Other

_____

### DIGESTIVE & URINARY
- ☐ Constipation
- ☐ Frequent Urination
- ☐ Diarrhea
- ☐ Irritable Bowel Syndrome
- ☐ Ulcerative Colitis
- ☐ Pelvic Inflammatory Disease
- ☐ Heartburn
- ☐ Gas and Bloating
- ☐ Liver/Gall Bladder
- ☐ Kidney/Bladder
- ☐ How many bowel movements per day: ____ or per week: _____
- ☐ Other

_____

### FEMALE
- ☐ Menstrual Problems
- ☐ Pregnant: Week: ____
- ☐ Menopausal Problems
- ☐ Endometriosis
- ☐ C-section
- ☐ Other

_____

### MALE
- ☐ Haemorrhoids
- ☐ Prostate Problems
- ☐ Hernias
- ☐ Other

_____

### SKIN
- ☐ Easily Bruise
- ☐ Eczema/Psoriasis
- ☐ Rash
- ☐ Cold Sores/Warts
- ☐ Herpes
- ☐ Athletes Foot
- ☐ Loss of Sensation
- ☐ Skin Conditions

_____

### ALERGIES
- ☐ No
- ☐ Yes

List:

_____

_____

### HEAD & NECK
- ☐ Headache
- ☐ Migraine
- ☐ Visual Disturbances
- ☐ Earaches
- ☐ Hearing Problems
- ☐ Teeth/Jaw Pain
- ☐ Locked Jaw
- ☐ Sinus Pain
- ☐ Dizziness/Vertigo
- ☐ Whiplash/ Injury

_____
(Date of accident)

- ☐ Other

_____

### MUSCLES & BONES
- ☐ Scoliosis
- ☐ Osteoporosis
- ☐ Carpal Tunnel Syndrome
- ☐ Bone/Joint Disorder

_____

- ☐ Fractured Bone

_____

- ☐ Arthritis

_____

- ☐ Tendonitis

_____

- ☐ Bursitis

_____

### OTHER
- ☐ Diabetes Type: ____
- ☐ Cancer

Type: _____

- ☐ HIV/AIDS
- ☐ Tuberculosis
- ☐ Hepatitis
- ☐ Insomnia
- ☐ Chronic Fatigue Syndrome
- ☐ Seasonal Affective Disorder
- ☐ Depression
- ☐ Fibromyalgia
- ☐ Haemophilia
- ☐ Other

_____

### Injury
Nature: Date:

_____

_____

### Surgery
Nature: Date:

_____

_____

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

- ☐ No
- ☐ Yes

What?

_____

Where?

_____

### LIFESTYLE CHECKLIST
- ☐ Exercise regularly _____x/week
- ☐ Consume caffeine _____x/week
- ☐ Consume alcohol _____x/week
- ☐ Smoke _____x/week

I understand that all written and verbal information gathered for/during treatment by a registered massage therapist is confidential. I declare that all above information is correct to the best of my knowledge, and if it should change (including medications, treatments, and diagnoses) it is my responsibility to notify the therapist of these changes at the next scheduled appointment. I understand that I will be asked for written authorization for release of any information outside of my circle of care as identified above.

Date:_____

Signature:_____

| Date of initial Health History: _____ | Initial Blood Pressure: _____ |
|---|---|
| Update 1: _____ | Update 1: _____ |
| Update 2: _____ | Update 2: _____ |