HOPE MASSAGE THERAPY

95 Bay Street, Woodstock, ON N4S 3K7 519-532-4466

Health History Form

The information requested below will assist us in treating you safely. Feel free to ask any questions about the information being requested. Please note that all information provided below will be kept confidential unless allowed or required by law. Your written permission will be required to release any information.

Name:_____ Phone #: _____

	apt/unit #	*street address*	*city*	*postal code*
Address:				

Occupation: _____ Date of Birth: _____

Did a heatlh care practitioner refer you to massage therapy? ☐ Yes ☐ No

If Yes, please provide their name and address: _____

_____

Please check if you have had any of these or are currently experiencing any of these:

Cardiovascular

☐ high blood pressure ☐ low blood pressure ☐ chronic congestive heart failure
☐ phlebitis / varicose veins ☐ stroke/CVA ☐ pacemaker or similar device
☐ heart disease

Respiratory

☐ chronic cough ☐ shortness of breath ☐ bronchitis
☐ asthma ☐ pneumonia ☐ C.O.P.D.

Is there a family history of any cardiovascular or respiratory conditions? ☐ Yes ☐ No

Infections

☐ hepatitis ☐ skin conditions ☐ herpes ☐ TB ☐ HIV

Other Conditions

☐ loss of sensation, where?_____
☐ diabetes, onset: _____
☐ allergies/hypersensitivity to what? _____
Type of reaction: _____
☐ epilepsy
☐ cancer, type and location?_____
☐ skin conditons, what? _____
☐ arthritis, type and location: _____
Is there a family history of arthritis? ☐ Yes ☐ No
☐ osteoporosis
☐ fibromyalgia
☐ muscular dystophy
☐ haemophilia
☐ mental health condition
☐ multiple sclerosis
☐ other diagnosed condition: _____

Please check if you have had any of these or are currently experiencing any of these:

Head/Neck

☐ history of headaches ☐ history of migraines

☐ vision problems ☐ vision loss ☐ wear glasses ☐ wear contact lenses

☐ ear problems ☐ hearing loss ☐ wear hearing aid

☐ pregnant, due: _____

☐ gynaecological conditions _____

Overall, how is your health? _____

Primary Care Physician**:** _____

Address: _____

Current Medications: _____

_____

Condition treated: _____

Are you currently receiving treatment from another health care professional? ☐ Yes ☐ No

If yes, for what? _____

Do you have any internal pins, wires, artificial joints or special equipment? ☐ Yes ☐ No

what? _____

where? _____

What is the reason that you are seeking massage therapy? (Please include the location of any tissue or joint discomfort)

_____

date: _____

update 1:
update 2:
update 3:
update 4:
update 5: