

HEALTH HISTORY FORM

The information on this form will be kept confidential except as required by law. Your written permission will be required to release any information. **It is important to be accurate** so that we can ensure it is safe for you to receive a massage treatment. If your health status or contact information changes in the future, please let us know.

Name: _____ Date: _____

Mailing Address: _____ City: _____ Postal Code: _____

Email Address: _____ Date of Birth: dd ____/mm ____/yy ____

Telephone: (home) _____ (work) _____ (other) _____

Occupation: _____ What is your primary complaint? _____

Extended health care plan? Yes No History of massage therapy? Yes No

Referred by: _____

Please be specific: name of friend, name of doctor, advertisement location, website, etc.

Please indicate conditions you are experiencing, or have experienced in the past:

HEAD / NECK

- headaches
- vision problems / loss
- contact lenses
- earaches
- hearing problems
- jaw pain / TMJ disorder

RESPIRATORY

- chronic cough
- shortness of breath
- asthma –Date of last attack: _____
- bronchitis / emphysema
- smoking

CARDIOVASCULAR

- CCHF
- heart attack
- stroke / CVA
- pacemaker / similar device
- high blood pressure
- low blood pressure
- heart disease
Type: _____
- poor circulation/bruise easily
- phlebitis
- varicose veins
Dr. diagnosed? yes no

INFECTIONS

- herpes
- hepatitis
- skin condition
Type: _____
- TB
- HIV / AIDS
- other: _____

OTHER CONDITIONS

- numbness & tingling
Areas: _____
- difficult digestion
- constipation / diarrhea
- IBS
- liver: _____
- gallbladder: _____
- kidney: _____
- diabetes –Type 1 or 2?
Onset: _____
- sinus: _____
- allergies (anaphylaxis or skin irritation): _____
- insomnia/fatigue
- depression
- cancer: _____
- epilepsy –Date of last seizure: _____
- osteoporosis

- arthritis
Dr. diagnosed? yes no
Areas: _____
- Family history? yes no
- menstrual problems / pain
- pregnancy –Due: _____
- menopausal problems: _____

OVERALL feeling of general health? _____

OTHER MEDICAL

CONDITIONS (including pins, wires, artificial joints or limbs, wheelchair, walker, cane, etc):

CURRENT MEDICATIONS

(including aspirin, herbs, vitamins, etc)

Name	Condition
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

Ottawa Professional Therapy Centre

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Please list the timing & nature of ANY injuries, accidents and surgeries

Type: _____
Date: _____
Current symptoms: _____

Type: _____
Date: _____
Current symptoms: _____

Type: _____
Date: _____
Current symptoms: _____

Type: _____
Date: _____
Current symptoms: _____

MUSCLES & JOINTS

Please indicate where you are currently experiencing pain or stiffness:

- neck / jaw: right / left
- shoulders: right / left
- arms: right / left
- hands: right / left
- mid back: right / left
- low back: right / left

- thighs: right / left
- knees: right / left
- lower legs: right / left
- ankles: right / left
- feet: right / left
- other: _____

OTHER HEALTH CARE

- massage therapy
- chiropractic
- physiotherapy
- psychotherapy

- acupuncture
- weekly exercise
- nutritional consultation
- other: _____

MEDICAL DOCTOR

Name: _____ Telephone: _____

Date of last visit: _____ Address: _____

Permission to send your Doctor a report pertaining to your health care? yes no

It is important for you to know that you may stop or modify your treatment at any time. Also, it is normal to experience side effects such as muscle achiness and tenderness for a period of up to 48 hours following your massage. Do you consent? Yes No

If an appointment is missed without 24 hours notice, you will be billed for the time booked.

Signature: _____

THANK YOU for taking the time to accurately fill out this health history form.

Date of initial Health History : _____
Update 1: _____
Update 2: _____
Update 3: _____
Update 4: _____
Update 5: _____
Update 6: _____
Update 7: _____