

**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

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

203 – 240 Catherine St, Ottawa ON K2P 2G8  
www.theoptc.com Tel: (613) 565-0763 info@theoptc.com

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: \_\_\_\_\_

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.

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

Do you consent?  Yes  No

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: _____