Health History

Name: ___________________________________ Date of Birth (D/M/Y) ________________ Sex: M/F

Address: ____________________________ Phone: (home): _______________________

____________________________ (work) : _______________________

Occupation: ____________________________ (cell): _______________________

Emergency contact: ____________________

Email:______________________________________

Relationship: ____________________ Primary Care Physician:_______________________

Phone: ____________________________ Address: ______________________________

Have you received massage therapy before? **Y / N**

Did a health care practitioner refer you for massage therapy? **Y / N** If so, Who? __________________

Overall how would you rate your general health? ____

What is the reason you are seeking massage therapy today?___________________________________

____

Please check off any of the following conditions that apply to you or write "F" if there is a family history:

CARDIOVASCULAR	RESPIRATORY	OTHER
__ High Blood Pressure	__ Chronic Cough	__ Epilepsy
__ Low Blood Pressure	__ Emphysema	__ Hepatitis
__ Congestive Heart Failure	__ Bronchitis	__ HIV
__ Phlebitis / Varicose Veins	__ Asthma	__ Herpes
__ Heart Attack / Infarction	__ Shortness of Breath	__ Diabetes
__ Stroke / CVA	__ Infectious Condition	__Tuberculosis
__ Heart Disease		__ Cancer
__ Pacemaker	**SKIN/ALLERGIES**	__ Arthritis
	__ Infectious Skin Condition	__ Headache
WOMEN	__ Rashes	__ Migraines
__ Pregnant	__ Bruise Easily	__ Vision/Hearing Loss
Due date:____________	__ Sensitivity to Fragrance	
__ Gynaecological condition	__ Loss of Sensation	
	__ Frostbite	
	__ Allergies	

Do you have any other diagnosed diseases or medical conditions? **Y / N** What? ___________________________

Do you have any internal pins, wires, artificial joints, or other special equipment? **Y / N** Where? _____________

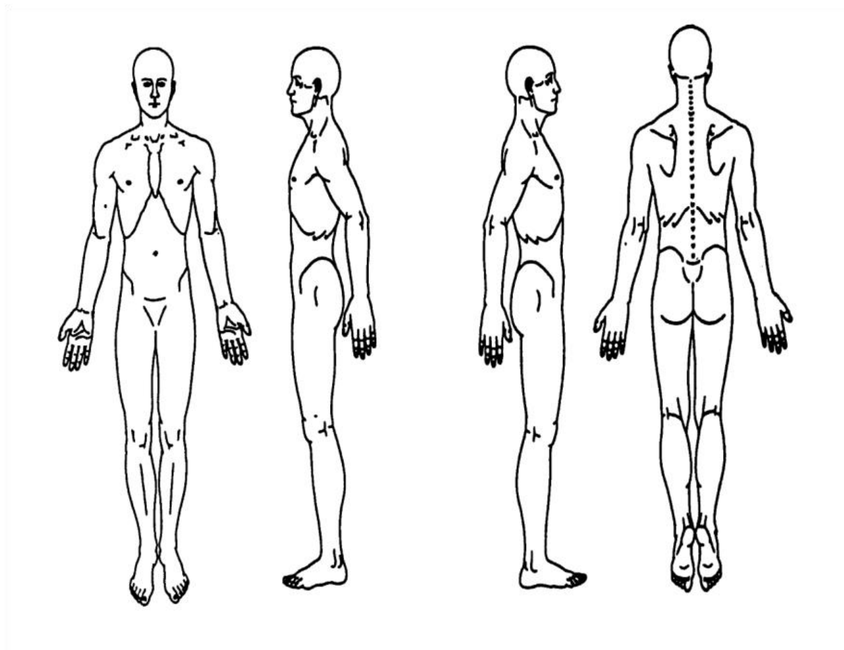
Are you currently taking any medication? **Y / N** For which condition(s): _________________________________

Are you currently receiving treatment from other health care providers? **Y / N**

For which condition(s):____

MUSCLE/JOINT PAIN:

Please circle current symptomatic areas on the diagrams below. You may indicate pain, numbness, stiffness, fractures, scars, swelling, etc.



INJURIES:

Please list any major injuries that happened to you in the past or are suffering from presently: (fractures, sprains, motor vehicle accidents, etc.)

____ Date: ___________________

____ Date: ___________________

____ Date: ___________________

SURGERIES:

Please list any minor or major surgery.

____ Date: ___________________

____ Date: ___________________

____ Date: ___________________

Do you have any other health concerns not mentioned above that you feel should be mentioned?

____

____

I hereby give consent for assessment and treatment by Jessica Ross, RMT/Jennifer Holmes, RMT/Vanessa McBain, RMT, and I understand that my consent can be withdrawn at any time. I acknowledge that the above information is complete to the best of my knowledge. I understand everything in my file will be kept confidential, unless required by law and with my written consent. **Cancellations must be made 24 hours in advance in order to avoid a cancellation fee**.

Signed : ____ Date : __________________________________

Update 1: ___________________ Update 2: ___________________ Update 3: ________________________

U
p
d
a
t