Confidential Information Health History Form

Welcome. Please take a moment to fill out this confidential health history form. This will ensure that you receive proper treatment and that it is safe for you to do so. Please note that all the information provided below will be kept confidential unless allowed or required by law. Your written permission will be required to release any information.

Name (please print): _____ Date of Birth:_____
Address: _____ City:_____
Postal Code:_____ Occupation:_____
Phone: Home#_____ Business/Cell#_____
How did you hear about us?_____
Have you received massage therapy before? **YES / NO**, if yes how long ago?_____
Physicians name/address/phone:_____
Medication (including non-prescription):
_____
Allergies: _____
Surgery/injuries/hospitalization: (date, past and current symptoms)_____
_____
Do you have any internal pins/wires/artificial joints? _____

Reason for your visit:
What is your primary complaint?_____
Can you describe it? **DULL SHARP SHOOTING ACHY NUMB TINGLING STIFF**
Pain Scale: 1(LOW)_____ 5_____ 10 (HIGH) What is your pain scale?
Does this pain radiate anywhere? **YES / NO**, if yes where? _____
Does anything aggravate your symptoms?_____
Does anything relieve your symptoms? _____
When did your symptoms begin? _____
Have they changed and how? _____
Does your symptoms interfere with: **WORK SLEEP DAILY ACTIVITIES** (please explain)
_____
Are you currently receiving treatment from another healthcare professional? **YES / NO**
If yes, for what?_____

This is to confirm and acknowledge that the above mentioned information is correct and accurate to my knowledge and that I give consent for treatment by a Registered Massage Therapist. I also acknowledge the policy that appointments canceled within less than 24 hours notice or missed will be subjected to a $30 charge.

Signature: _____ Date:_____

PLEASE SEE OTHER SIDE

Please circle all that apply

HEAD/NECK
Headache
Migraine
Visual Disturbances
Contact lenses/ glasses
Earaches
Hearing Problems
Jaw Pain
Dental problems
Whiplash

DIGESTIVE/URINARY
Irritable bowel
Difficult Digestion
Constipation
Liver/ Gallbladder
Kidney/Urinary
Diabetes (Type & Onset)
Hypoglycemia
Ulcers
Crohn's disease

MUSCLE/JOINTS
Neck
Low back
Mid back
Upper back
Shoulder R/L
Hip
Knees: R/L
Ankle: R/L
Other: _____

CARDIOVASCULAR
High blood pressure
Low blood pressure
Chronic Congestive Heart Failure
Poor circulation
Heart disease
Phlebitis
Stroke
Heart attack
Pacemaker
Arteriosclerosis
Irregular heart beat

SKIN
Bruise easily
Eczema
Psoriasis
Sensitivity
Skin condition
(please specify)
_____
Loss of sensation
(describe)
_____
Athlete's foot
Cold sores
Plantar warts

FEMALE
Menstrual problems
Pregnancy
Due Date: _____
Menopausal problems
Gynecological conditions

RESPIRATORY
Asthma
Chronic cough
Shortness of breath
Bronchitis
Emphysema
Smoker

INFECTIOUS CONDITIONS
Tuberculosis **Y** **N**
AIDS/HIV **Y** **N**
Hepatitis Type _____
Infectious Skin conditions
(please specify)
_____

OTHER
Hemophiliac
Epilepsy
Cancer, Location _____
Arthritis OA RA
Family History _____
Fibromyalgia
Osteoporosis
Chronic fatigue syndrome
Fainting / dizziness / loss of consciousness
Hernia

I acknowledge that East Windsor Massage Therapy Clinic is committed to providing a workplace free of discrimination and harassment based on race, colour, religion, national origin, ancestry, age, disability, sexual orientation, sex, etc.
I also understand that any type of harassment or discrimination will not be tolerated. Should any party involved in a massage therapy treatment upset this policy, the treatment will end immediately.
This is to confirm and acknowledge that the above mentioned information is correct and accurate to my knowledge and that I give consent for treatment by a Registered Massage Therapist.

Signature: _____ Date:_____