Tri-City Natural Health Care Centre
528 King Street East
Cambridge, Ontario N3H 3N2
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MASSAGE THERAPY

Date: / /
Day Month Year

CONFIDENTIAL HEALTH HISTORY FORM

An accurate health history form is important to ensure that it is safe for you to receive a massage treatment. All information is confidential (except as required by law) and is used only fro my clinical assessment and treatment plan. You will be asked to provide written authorization for release of any information

Email: _____

Name: _____ Home Tel: _____ Bus Tel: _____ Cell: _____

Address: _____ City: _____ Postal Code: _____

Date of Birth: _____ Age: ____ M/F: _____ Occupation: _____ Height: ____ Wt: _____

Family Physician: _____ Address: _____ Tel: _____

Emergency Contact: _____ Address: _____ Tel: _____

What is your primary complaint? _____

Who is treating you for this? _____

Have you ever received a massage before? ____ How long ago? _____ Where did you hear about this clinic? _____

HEALTH HISTORY - PLEASE CHECK ALL THAT APPLY *Please check the following conditions that apply to you, past and present:*

C = Current P = Previous disorder

Muscles and Joints

Pain/Stiffness

Neck / shoulder	C __ P __
Jaw / face	C __ P __
Chest / rib	C __ P __
Elbow / wrist	C __ P __
Back: Upper, Mid, Low	C __ P __
Hip	C __ P __
Knee	C __ P __
Ankle	C __ P __

Diagnosed Conditions

Whiplash	C __ P __
Arthritis ( )	C __ P __
Osteoporosis	C __ P __
Scoliosis	C __ P __
Tendonitis / Bursitis	C __ P __
Sprains / Strains	C __ P __
Spasms / Cramps	C __ P __
Fractures	C __ P __
TMJ	C __ P __
Bone / Joint disease	C __ P __

Other: _____

Reproductive

Women

Painful / irregular Menstruation	C __ P __
Gynecological conditions	C __ P __
PMS	C __ P __
Menopause	C __ P __
Hysterectomy	C __ P __
Pregnancy ___ # months	_____
# of Children	_____
Diagnosed Disorders	_____

Men

Prostate problems	C __ P __
Diagnosed Disorders	_____

Respiration

Short of breath	C __ P __
Chronic coughing	C __ P __
Bronchitis	C __ P __
Asthma	C __ P __
Emphysema	C __ P __
Allergies	C __ P __
Smoker - How many per day?	_____
Diagnosed Disorders	_____

Digestive

Poor appetite	C __ P __
Nausea	C __ P __
Indigestion	C __ P __
Constipation	C __ P __
Diabetes Type?	C __ P __
Hernia / Ulcer	C __ P __
Kidney / Bladder	C __ P __
Liver / Gall Bladder	C __ P __
Diagnosed Disorders	_____

General

Stress	C __ P __
Dizziness	C __ P __
Sinus problems	C __ P __
Drug / Alcohol addiction	C __ P __
Cancer / Tumors	C __ P __
Allergies	C __ P __
Disturbed sleeping patterns	C __ P __
Ear problems	C __ P __
Vision problems	C __ P __
Headaches	C __ P __
List Type	_____

Circulatory

Heart Disease	C __ P __
Cardiac Infarction	C __ P __
Stroke	C __ P __
Congestive Heart Failure	C __ P __
Varicose Veins	C __ P __
Thrombosis	C __ P __
Phlebitis	C __ P __
Hemophilia	C __ P __
Edema	C __ P __
Low Blood Pressure	C __ P __
High Blood Pressure	C __ P __
Epilepsy	C __ P __

Diagnosed Disorders _____

Skin

Sensitive Skin	C __ P __
Bruise Easily	C __ P __
Rashes / Eruptions	C __ P __
Cold Sores	C __ P __
Warts	C __ P __
Plantar Warts	C __ P __
Athletes Foot	C __ P __
Scars	C __ P __
Infectious skin conditions	C __ P __

Diagnosed Disorders _____

Infectious Diseases

HIV / AIDS	C __ P __
TB	C __ P __
Hepatitis	C __ P __

Exercise and Health Habits

Regular Sleeping Pattern	Yes__ No __
Good Eating Pattern	Yes__ No __
Regular Exercise Routine	Yes__ No __

Other Medical Conditions - Please be specific: _____

Special Note: (use of pins, wires, prosthetics, artificial joints, walker, cane, etc.) _____

Surgeries / Accidents

Date: _____ *Day / Month / Year* Type: _____

Date: _____ *Day / Month / Year* Type: _____

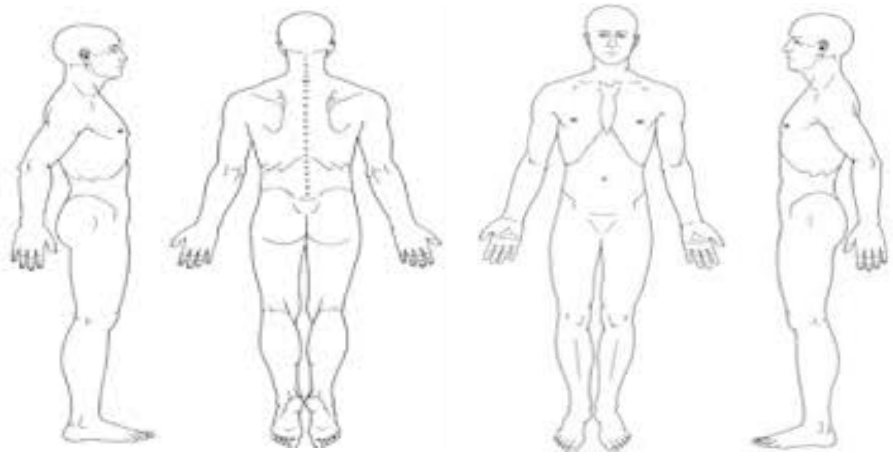
Please list any current medications and the conditions they are for (including over-the-counter medications):

1 _____ for _____

2 _____ for _____

3 _____ for _____

4 _____ for _____



Please indicate affected areas on drawing:

P = Pain
S = Stiffness
N = Numbness or tingling

I have stated all the conditions of which I am aware of in this health history form. This information is accurate. I will inform the Massage Therapist of any changes in the future. I understand that massage therapy is intended to offer treatment for stress, pain relief, improved mobility and relaxation. I have the right to ask questions about my treatment and that I am in control of my treatment at all times, including the right to ask the therapist to stop or change the treatment at any time during the treatment session. I understand that my verbal consent is the same as written consent.

Client Signature: _____ Date: (DD/MM/YY): _____