Name:_____
Address:_____
City:_____ Prov:_____
Postal Code:_____
Phone(H):_____(W):_____
Current Date:_____
EMAIL: _____
Family Physician:_____
Address:_____
Phone:_____

Date of Initial Health History: _____
Update 1 _____
Update 2 _____
Update 3 _____
Update 4 _____

Referred By:_____
Emergency Contact:_____
Phone:_____

☐Female ☐Male
Date of Birth(YYYY/MM/DD):_____
Occupation: _____
What is your general health status?_____
What is your dominant hand?
☐ Left ☐ Right
What is your primary sleeping position?
☐ Side ☐ Back ☐ Front
Do you smoke? ☐ No ☐ Yes
If yes, how much per day:_____
Are you currently taking **ANY** medication?
☐ No ☐ Yes
Name medication and condition including **supplements**:
_____
_____
_____
_____

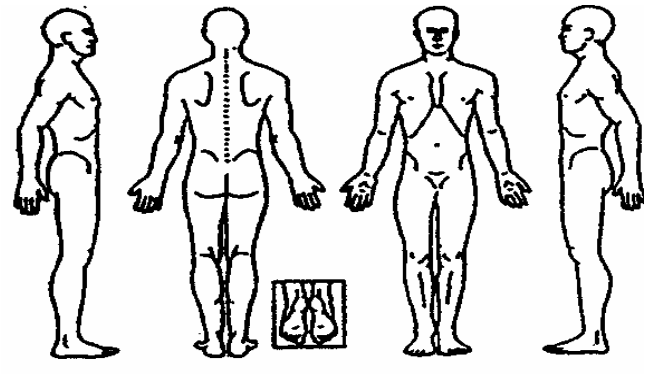
Are you, or are you possibly pregnant?
☐ No ☐ Yes
Expected due date:_____
Do you exercise regularly? ☐ No ☐ Yes
Frequency: ____x/week
What are your recreational activities:
_____
_____
Do you have any internal pins, wires, artificial joints or other special equipment (such as a pacemaker or hearing aid)?
☐ No ☐ Yes
If yes, please explain:
_____
Have you ever seen a Massage Therapist? _____
If yes, what is their name? _____
When was your last treatment?_____

Have you ever been in a motor vehicle accident, sustained an athletic injury or other trauma? ☐No ☐Yes
Date:_____ Reason:_____
Date:_____ Reason:_____
Date:_____ Reason:_____

Have you ever been hospitalized? ☐ No ☐ Yes
Date:_____ Reason:_____
Date:_____ Reason:_____
Date:_____ Reason:_____

Have you ever had surgery? ☐ No ☐ Yes
Date:_____ Reason:_____
Date:_____ Reason:_____
Date:_____ Reason:_____

What is the purpose of your visit: _____
What started this condition: _____
When did this condition begin: _____
What aggravates this condition: _____
What relieves this condition: _____
Have you received treatment from other healthcare providers for this condition? ☐ No ☐ Yes
If yes, who are they and what type of healthcare provider are they:
_____
_____



please fill out information on the back

Please circle current symptomatic areas in your body on the diagrams above.

Have you been diagnosed with, or have you ever experienced any of the following?
If **Yes**, please mark with an "**X**" on the line provided.

Circulatory/Respiratory

___ Chronic congestive heart failure
___ Heart disease
___ Other heart condition
___ High blood pressure
___ Low blood pressure
___ Varicose veins
___ Phlebitis
___ Deep vein thrombosis
___ Raynaud's disease/phenomenon
___ Buerger's disease
___ Chronic cough
___ Bronchitis
___ Asthma
___ Emphysema
___ Shortness of breath

Nervous system

___ Epilepsy
___ Multiple sclerosis
___ Cerebral palsy
___ Parkinson's
___ Nerve lesion
___ Sciatica
___ Carpal tunnel syndrome

Musculoskeletal

___ Scoliosis
___ Bone or joint disease
___ Arthritis
___ Joint instability
___ Tendinitis
___ Fractured bones
___ Jaw pain (TMJ)
___ Whiplash

Skin

___ Sensitivities to oils, lotions, detergents
___ Other allergies or hypersensitivities
___ Irritated skin conditions
___ Contagious conditions
___ Frostbite
___ Lack of sensation

Have you ever suffered from:

Heart Attack ☐ No ☐ Yes
Date:_____
Stroke ☐ No ☐ Yes
Date:_____

General

___ Cancer/Tumours
___ Undiagnosed lump
___ Diabetes
___ Kidney problems
___ Liver problems
___ Drug/Alcohol addiction or withdrawal
___ Infectious conditions (hepatitis, HIV, etc.)
___ Eating disorder
___ Recent abortion or vaginal birth
___ Loss of vision or hearing

Please list any other condition not listed & provide details as necessary

_____
_____
_____
_____
_____
_____
_____
_____

I,_____ hereby declare that all of the above information is correct, and if it should change, it is my responsibility to notify the therapist of these changes at the next scheduled appointment.

Signature of Client:_____ **Date:**_____
Signature of Parent/Guardian (if applicable):_____ **Date:**_____