Health History Form

Registered Massage Therapy at Clarity Chiropractic
1890 Glenview Rd. Pickering, ON, L1V 1W8

The information requested below will assist us in treating you safely. Feel free to ask any questions about the information being requested. Please note that all information provided will be kept confidential unless allowed or required by law. Your express permission will be required to release any information.

Name: ____ Phone: ______________________

Address: ____

Occupation: ____ Date of Birth: _________________

Have you received massage therapy before? [ ] yes [ ] no

If yes, please provide their name and address. ____

____

Please indicate conditions you are experiencing or have experienced:

Cardiovascular

[ ] high blood pressure
[ ] low blood pressure
[ ] chronic congestive heart failure
[ ] heart attack
[ ] phlebitis/varicose veins
[ ] stroke/CVA
[ ] pacemaker or similar device
[ ] heart disease

Is there a family history of any of the above? [ ] yes [ ] no

Respiratory

[ ] chronic cough
[ ] shortness of breath
[ ] bronchitis
[ ] asthma
[ ] emphysema

Is there a family history of any of the above? [ ] yes [ ] no

Infections

[ ] hepatitis
[ ] skin conditions, what? ___________
[ ] TB
[ ] HIV
[ ] herpes

Other Conditions

[ ] loss of sensation, where?

____

[ ] diabetes, onset: ________________

Allergies/hypersensitivity to what?

____

Type of reaction _________________

[ ] epilepsy
[ ] cancer, where? ________________
[ ] skin conditions, what?

____

[ ] arthritis

Is there a family history of arthritis? [ ] yes [ ] no

Head/Neck

[ ] history of headaches
[ ] history of migraines
[ ] vision problems
[ ] vision loss
[ ] ear problems
[ ] hearing loss

Women

[ ] pregnant, due: __________________
[ ] gynecological conditions, what?

____

Overall, how is your general health?

Primary Care Physician:

____

Address:

____

Current Medications:

____

Condition it treats:

____

Are you currently receiving treatment from another health care professional? [ ] yes [ ] no

If yes, for what? ________________________________

____

Surgery-date: ___________________________________

Nature: ____

Injury-date: ____________________________________

Nature: ____

Do you have any other medical conditions? (eg digestive conditions, hemophilia, osteoporosis , mental illness) [ ] yes [ ] no

What? ____

Do you have any internal pins, wires, artificial joints or special equipment? [ ] yes [ ] no

What? ____

Where? ____

What is the reason you are seeking massage therapy? Please include the location of any tissue or joint discomfort .

____
____
____

Notes:

Date of initial Health History: _________
Update 1: _________
Update 2: _________
Update 3: _________
Update 4: _________

Signed:

Dated:

Treatment notes for: ___________________________

Date:_____________ Time: _________ am pm Duration: _______ min hr Fee $________

Informed consent received: treatment assessment Therapist: _______________

Techniques Used:

Swedish frictions deep facial trigger points stretch intra-oral

Breast massage hydrotherapy joint mobilization grade: ______ other (list) _______

Areas Treated

Back neck face shoulder arm L R leg L R

Hip area abdominals chest breast other (list) ____________________________________

Clinical findings:

Client reaction feedback:

Recommended self-care:

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