

## Health History Questionnaire

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 below will be kept confidentially unless allowed or required by law. Your written permission will be required to release any information.

Name:				Today's Date: D D / M M / Y Y Y Y									
Address:				Apartment #:									
City:		Prov.:		Postal Code:									
Home Phone: (      )		Cell Phone: (      )											
Work Phone: (      )		Email:											
How would you prefer we contact/follow-up with you in the future: Home <input type="checkbox"/> Work <input type="checkbox"/> Cell <input type="checkbox"/> Email <input type="checkbox"/>													
Occupation:		Language Preference:		Date of Birth: D D / M M / Y Y Y Y									
Emergency Contact Name:				Emergency Contact Number:									
Have you received massage therapy in the past? Y <input type="checkbox"/> N <input type="checkbox"/>				Were you referred for massage? Y <input type="checkbox"/> N <input type="checkbox"/>									
Please provide their name and contact information:													
<b>What is your reason for seeking massage therapy today? When did this issue begin?</b>													
What is related to an injury, accident or surgery? Y    N													
Are you currently experiencing pain, stiffness, tension?(Where/when/how):													
Please indicate (✓) any conditions you currently have (C), have experienced in the past (P), or there is a family history (F) of:													
CARDIOVASCULAR			HEAD & NECK			FEMALE CLIENTS							
High/Low Blood Pressure	C	P	F	Headaches	C	P	F	Pregnant	C	P	F		
Pacemaker	C	P	F	Migraines	C	P	F	Hysterectomy	C	P	F		
Congestive Heart Failure	C	P	F	Hearing Loss	C	P	F	Menopause	C	P	F		
Varicose Veins	C	P	F	Vision Issues	C	P	F	Acute Injury/Infection/Illness					
Stroke/Embolicism	C	P	F	Vision Loss	C	P	F	Brusing	C	P	F		
Heart Disease	C	P	F	OTHER CONDITIONS			Fever	C	P	F			
RESPIRATORY			Arthritis	C	P	F	Pain and or swelling/inflammation			C	P	F	
Chronic Cough	C	P	F	Where?			Generalized loss of muscle strength			C	P	F	
Bronchitis	C	P	F	Allergies	C	P	F	Increased BP or heart rate			C	P	F
Asthma	C	P	F	To what?			Is your general health good?			Y	N		
Emphysema	C	P	F	Cancer	C	P	F	Current Medications:					
Sleep Apnea	C	P	F	Where?									
Shortness of Breath				Diabetes	C	P	F						
				Epilepsy									
	C	P	F	Loss of Sensation				Where?					
				Skin conditions				What?					
Are you currently receiving treatment from another healthcare professional? Y <input type="checkbox"/> N <input type="checkbox"/>													
If yes, what for?													
Do you have any other medical conditions? (ex. digestive, osteoporosis) Y <input type="checkbox"/> N <input type="checkbox"/>													
If yes, what?													
Do you have any internal pins, wires, artificial joints or special equipment? Y <input type="checkbox"/> N <input type="checkbox"/>													
If yes, what/where?													
Surgery:			Date:		Surgery:			Date:					
Injury:			Date:		Injury:			Date:					
Health History Update 1: D D / M M / Y Y				Update 2: D D / M M / Y Y				Update 3: D D / M M / Y Y					
Primary Care Physician:				Address:				Phone:					