WatersEdge Massage Therapy & Wellness Centre

Health History Form

The information request 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 confidential unless allowed or required by law. Your written permission will be required to release any information

Name:____ **Phone #**_______________

Address:____

Occupation:___________________________________ **D.O.B**________________

Have you received massage therapy previously? Yes ☐ **No** ☐ **Email:** ____________________

Do we have permission to email you: Birthday Greetings? Yes ☐ **No** ☐ **Clinic Updates? Yes** ☐ **No** ☐

Did a Health care practitioner refer you for massage therapy? Yes ☐ **No** ☐

If yes, please provide their name and address:_______________________________________

Please indicate conditions you are experiencing or have experienced:

Overall Health

Overall , how is your general health?

____

Primary Care Physician:

Name:_________________________

Address:_______________________

____

Phone #________________________

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? (e.g. digestive, hemophilia, osteoporosis, mental illness)

Yes ☐ No ☐ If Yes what condition ____

Do you have any internal pins, wires, artificial joints or special equipment?

Yes ☐ No ☐ If yes What & Where:____

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

____

Head/Neck

- History of headaches
- History of migraines
- Vision problems
- Vision loss
- Ear problems
- Hearing loss

Women:

- Pregnant? Due Date____________
- Gynecological conditions? If yes provide details :

____

Cardiovascular

- High Blood Pressure
- Low Blood Pressure
- Chronic congestive heart failure
- Heart attack
- Phlebitis/varicose veins
- Stroke/CVA
- Heart Disease

Is there a family history of any of the above:

Yes ☐ No ☐

Infections:

- Hepatitis
- Skin Conditions
- TB
- HIV
- Herpes

Other Conditions:

Loss of sensation: Where?__________________________

Diabetes, Onset___________________________________

Allergies/Hypersensitivity to what?__________________

Type of reaction?_________________________________

Epilepsy? Yes ☐ No ☐

Cancer? Where?__________________________________

Skin condition, What?______________________________

Arthritis? Yes ☐ No ☐

Is there a family history of arthritis? Yes ☐ No ☐

Respiratory

- Chronic cough
- Shortness of breath
- Bronchitis
- Asthma
- Emphysema

Is there a family history of any of the above? Yes ☐ No ☐

Current Medications	Condition it treats:
1.____________________	1.____
2.____________________	2.____
3.____________________	3.____
4.____________________	4.____

(For Therapist) Date of Initial Health History: ______________________

Update 1: ________________________ Update 2: __________________

Update 3: ________________________ Update 4: __________________