Personal Health History Information

All information is confidential.
Please note there is a 24 hour cancellation fee of $45.00

PERSONAL DATA

Name: _____ **Date:** _____ **Date of update:** _____

Address: _____ **Phone (day):** _____

City: _____ **Phone (evening):** _____

Postal Code: _____ **Occupation/employer:** _____

Birthday: _____ **Emergency Contact & Phone #:** _____

Medical Doctor Name: _____ _____

Medical Doctor Address/Phone #: _____ **How did you hear about us? (please be specific):**

_____ _____

_____ _____

Chiropractor/Physiotherapist: _____ **E-mail:** _____

_____

Permission to consult with your doctor, chiropractor or physiotherapist, please initial if yes: ☐**yes** _____ ☐**no**

Massage History/ Treatment Information

Have you ever received a professional massage? ☐ YES ☐ NO If yes, frequency _____ date of last massage_____

What is your primary reason for coming today?_____

Please indicate the areas in which you currently have pain.

☐ Head
☐ Neck
☐ Shoulders __right __left
☐ Arms __right __left
☐ Back __upper __mid __lower
☐ Buttocks __right __left
☐ Hips __right __left
☐ Legs __right __left
☐ Feet __right __left

Are you taking any prescription medications? ☐YES ☐NO_____

If yes, for what condition are these medications for?_____

Are you taking any over the counter medications or homeopathic supplements?☐YES ☐NO_____

If yes, for what condition are these medications for?_____

Have you taken an antiinflammatory (prescription, ibufrophen, motrin, advil etc.) today?☐YES ☐NO_____

If yes, for what condition are these medications for?_____

Head

☐ Headaches **Type:** ☐Migraine ☐Tension **Frequency:** _____ **Intensity:** ☐Mild ☐Severe **Duration:** ☐Hours ☐Days
☐ Concussion
☐ Head Injury
If so, please describe condition **and** treatment received: _____

_____

Vision/ Hearing/ Sinus

☐Eye Injury or Surgery ☐Glaucoma
☐Vertigo (dizziness) ☐Hearing Aids ☐Ear Infections ☐Ear Injury or Surgery ☐Deafness
☐Sinusitis ☐Chronic Sinus Infections ☐Nose Surgery ☐Fractures
If yes, please describe:_____

_____

Jaw or TMJ Dysfunction

☐Surgeries ☐Fractures ☐Implants ☐Braces ☐Lock Jaw ☐Unusual Dental Experiences
If yes, please describe:_____

_____

Neck

☐Whiplash(car accidents, falls, sports injury, diving) ☐Burning neck pain ☐Tension ☐Stiffness
If yes, please describe:_____

_____

Neurological

☐Fainting ☐Blackouts ☐Seizures ☐Paralysis ☐Memory Loss ☐Weakness ☐Numbness
☐Tingling ☐Tremors ☐Sciatica
If yes, please describe:_____

_____

☐Anxiety Attacks ☐Nervousness ☐Depression ☐Multiple Personality Disorders ☐Emotional Dysfunction
If yes, please describe:_____

_____

Respiratory

☐Asthma ☐Bronchitis ☐Emphysema ☐Pneumonia ☐Pleurisy ☐Shortness of Breath
☐Chronic/ Morning Cough
If yes, please describe:_____

_____

Cardiovascular/ Heart

☐Heart Disease ☐Atherosclerosis ☐Heart Attack ☐Stroke ☐Heart Murmur ☐Angina ☐Gout
☐High Blood Pressure ☐Palpatations ☐Leg Cramps ☐Varicose Veins ☐Phlebitis ☐Rheneauds Disease
☐Low Blood Pressure ☐Chronic Congestive Heart Failure ☐Pacemaker /Similar Device ☐Hemophilia
If yes, please describe:_____

_____

Digestive/ Uro-genital

☐Poor Appetite ☐Constipation ☐Liver ☐Gall Bladder ☐Kidney ☐Bladder ☐Diabetes
☐Stomach(ulcers) ☐Diarrhea ☐Hernia(hiatus)
If yes, please describe:_____

_____

Reproductive System

Men:
☐Prostate Symptoms ☐Testicular Cancer ☐Bladder Infections
If yes, please describe:_____

_____

Women:
☐Menstrual Problems ☐Miscarriage ☐Abortion ☐Still Birth ☐Hysterectomy ☐Menopause
☐Pregnancies and Delivery Complications ☐C-Section ☐Epidural ☐PMS ☐D&C ☐Breasts Problems

☐Pregnant ____ weeks _____Due Date

If yes, please describe:_____

_____

Muscles, Joints, Tendons, Ligaments

☐Tendonitis ☐Bursitis ☐Carpel Tunnel Syndrome ☐Thoracic Outlet Syndrome ☐Frozen Shoulder
☐Torticollis (wry neck) ☐Subluxation (disc) ☐Herniation (disc) ☐Prolapsed Disc ☐Joint Dislocation
☐Sprain/Strain ☐Fibromyalgia ☐Fibromyositis ☐Chronic Fatigue Syndrome ☐Epstein Barr Syndrome
☐Spondylolisthesis

If yes, please describe:_____

_____

_____

Injuries

☐Fractures ☐Contusions ☐Dislocations ☐Traction ☐Casts ☐Pins/wires ☐Lacerations ☐Implants
☐Motor Vehicle Accidents (date of accident:_____ describe collision:_____)

If yes, please describe:_____

_____

Other Conditions

☐Insomnia ☐Epilepsy ☐HIV or STD ☐Hepatitis ☐Cancer ☐Thyroid ☐Bulimia
☐Anorexia ☐Rheumatoid Arthritis ☐Osteoarthritis ☐Tuberculosis
Allergies: ☐Skin irritations ☐Anaphylaxsis ☐Eczema

If yes, please describe:_____

_____

Surgery

Please list any/all surgeries that you have had for any condition. Please include type of surgery, date and for what condition.

_____

_____

_____

I understand that all the massage therapists at Live Well Massage Therapy are Registered Massage Therapists and that all of my information is kept confidential. I understand that my written consent is required to release information to other health care professionals. I realize that it is my choice to receive massage therapy and that massage therapy is given for the well-being of my body and mind. This includes stress relief, decreasing pain, muscular tension, joint dysfunction and any musculoskeletal dysfunction. I agree to communicate with my massage therapist if I feel my well being is being compromised.

I understand that massage therapists do not diagnose illness, disease or any physical or mental disorder; nor do they prescribe any medical treatment, pharmaceuticals, or perform spinal thrust manipulations.

All information given is up to date and includes all conditions that I am aware of. I will notify my therapists of any changes to my health status.

Signature:_____ Date:_____