ACTIVEREHAB CENTRE

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# HEALTH HISTORY FORM

## PATIENT INFORMATION

| *Last name: | *First name: | Occupation: |
|---|---|---|
| | | |

Did a health care practitioner refer you for massage therapy?: ☐ Yes ☐ No

If yes, please provide their name and contact info:

*Have you received massage therapy before?: ☐ Yes ☐ No

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

## MEDICAL HISTORY & INFORMATION

Overall, how is your general health?:

Are you currently receiving treatment from another health care professional?: ☐ No ☐ Yes – if yes, for what?
____________________________

Are you currently taking any medications?: ☐ No ☐ Yes – if yes, what & why?
____________________________________

***Have you had any (Please note the date if yes to any of the below, and any relevant details):**

| Automobile accidents?: | Surgeries?: | Broken bones?: | Falls/Major injuries?: |
|---|---|---|---|
| | | | |

Internal pins, wires, artificial joints or special equipment?:

*Please check any of the following conditions you have/had:

| | | | |
|---|---|---|---|
| ☐ Aids/HIV | ☐ Digestion Problems | ☐ High Blood Pressure | ☐ Skin Conditions |
| ☐ Allergies | ☐ Ear Problems | ☐ Low Blood Pressure | ☐ Stroke |
| ☐ Arthritis | ☐ Emphysema | ☐ Loss Of Sensation | ☐ Thyroid Problems |
| ☐ Asthma | ☐ Epilepsy | ☐ Mental Illness | ☐ TB |
| ☐ Bronchitis | ☐ Haemophilia | ☐ Osteoporosis | ☐ TMJ |
| ☐ Chronic Cough | ☐ Headaches/Migraines | ☐ Pacemaker | ☐ Varicose Veins |
| ☐ Cancer | ☐ Hearing loss | ☐ Poor Circulation | ☐ Vertigo/Dizziness |
| ☐ Chronic Fatigue | ☐ Heart Attack / Disease | ☐ Sciatica | ☐ Vision Problems/Loss |
| ☐ Deafness | ☐ Hepatitis | ☐ Shingles | ☐ Other: |
| ☐ Diabetes | ☐ Herpes | ☐ Shortness Of Breath | _________________ |

Family History of:

- ☐ Arthritis
- ☐ Cancer
- ☐ Diabetes
- ☐ Heart Problems
- ☐ High/Low Blood Pressure
- ☐ Respiratory Conditions

## FEMALES

*Are you pregnant?: ☐ Yes ☐ No

Do you have any gynecological conditions?: ☐ No ☐ Yes – if yes, what? ____________________________________________________

## AGREEMENT

I confirm that the information I have provided in regards to my current condition and past health history are to the best of my knowledge. I also acknowledge that it is my responsibility to update the clinic in regards to any changes in my health condition. I also authorize the release of my medical condition to my family physician.

____________________________________________ ____________________

Patient/Guardian signature Date