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Health History Intake Form

Please assist me in treating you safely and effectively by filling out the form below as accurately as possible. 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: _____ Phone #: _____
Address: _____Apt:___City:_____Postal Code:_____
Occupation: _____ Date of Birth: _____
Email:_____
Would you like to receive updates (infrequently)? ☐ Yes ☐ No
Physician Name:_____Date of Last Physical:_____
Physician Address:_____Physician Phone:_____
Emergency Contact:_____Phone Number:_____
How did you find me? Internet search☐; Flyer ☐; Sign☐; Referral☐ Who:_____
Other ☐ please specify_____
Have you received massage therapy before? ☐ Yes ☐ No If yes, when was your last massage?_____

Did a health care practitioner refer you for massage therapy? ☐ Yes ☐ No
If yes, please provide their name: _____

Main reason for coming (areas of pain/tension/discomfort):_____
_____
Other health care received in the past year: (Please circle all that apply) Chiropractic Physiotherapy Osteopathy Acupuncture Naturopath Massage Reflexology Shiatsu Other:_____
Medications or vitamins/ treating what condition: _____
_____
List what you do for regular exercise:
_____

Recent Hospitalizations (Date/Why):_____
Surgeries (Date/ Current Symptoms): _____
_____
Car Accidents or Injuries (Date/ Current Symptoms): _____
_____
_____

Please indicate conditions you are currently experiencing or have experienced in the past:

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

Respiratory
☐ chronic cough
☐ shortness of breath
☐ bronchitis
☐ asthma
☐ emphysema

Infections
☐ hepatitis
☐ skin conditions
☐ TB
☐ HIV
☐ herpes
☐ warts

Other
☐ arthritis
☐ loss of sensation
☐ diabetes
☐ allergies
☐ epilepsy
☐ cancer
☐ headaches / migraines
☐ pregnant, due:_____

Additional Information :_____
_____

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

I certify that the information given in this form is correct and accurately reflects my past and current health status. I will notify the therapist of any changes that occur as soon as possible. I understand that the information requested will assist my therapist in treating me safely and that I can ask questions regarding this information. I am aware that before each massage I will give consent for treatment; I am also aware that my consent may be revoked at any time I choose. This information will be kept confidential unless required by law or after I have given written consent to release information.
I agree to provide 24 hours notice to change or cancel my appointment or I will be charged the full appointment fee.
☐ I give permission for the clinic to contact me via mail or email (e.g. Newsletters, cards, etc.)
☐I give permission to confirm treatment dates/durations for insurance inquiries - not treatment details

Date:_____ **Signature:**_____

For office use only:

*Update 1:*_____*Initials:*_____
*Update 2:*_____*Initials:*_____

Date:_____ **Time:**_____**Duration:**_____**min./hr. Fee $**_____
Informed consent received: treatment☐ assessment☐ Invoice #_____ **Therapist:**_____

stroking rocking vibration effleurage petrissage light mod. deep forearm/elbow:_____ tapotement myofascial release trigger point stretch/PROM joint mobilization/scap mob intra-oral manual lymph drainage breast massage IC_____ hydrotherapy:_____ Location:_____ other (list):	back: Upper Mid Low Pr/Su neck Pr/Su shoulders L R face/scalp Pr/Su arm L R hands Pr/Su forearm L R Pr/Su thigh L R feet Pr/Su calf L R gluteus abdomen/hip flexor chest/breast Position: SL ElevSup PALP:	Include clinical findings; client reactions/feedback to treament; recommended self-care; used and/or recommended remedial exercises, used and/or hydrotherapy; advice given) CC: SC: H2O Hydro: Stretch: