Healthy Choice
massage therapy clinic

Date and Initial Updates *(office use only)*
1. ____________ ____________
2. ____________ ____________
3. ____________ ____________
4. ____________ ____________

Confidential Health History Form

Current Date ____________________
Client Name ____________________
Address ____________________
City __________ Postal Code __________
Dr. Name ____________________
Dr. Telephone ____________________
Date of Birth ____________________
Referred By ____________________

Telephone (H) ____________________
Telephone (W) ____________________
Telephone (C) ____________________
Email ____________________
Occupation ____________________
Emergency Contact ____________________
Emergency Telephone ____________________

Involvement in treatment with other Health Care Practitioners
____

Current medications	Taking for

Please check all current and past conditions

Musculo-Skeletal Structure

Neck Pain	☐	Neck Stiffness	☐	Whiplash	☐
Neck Injury	☐	Mid Back Stiffness	☐	Mid Back Pain	☐
Weakness	☐	Tingling	☐	Numbness	☐
Scoliosis	☐	Lower Back Pain	☐	Lower Back Stiffness	☐
Degenerating Disc	☐	Osteoporosis	☐	Injuries/Surgery	☐
Head Trauma	☐	Arthritis	☐	Family History of Arthritis	☐
Headaches	☐	Migraine	☐	Tooth/Jaw/Ear Pain	☐
Hearing Loss	☐	Vision Loss	☐		

Comments ____

Injuries and Surgeries ____

Do you have any internal pins/wires/artificial joints? ____________________

History of Massage Therapy ____

Circulatory Conditions

Cold hands/feet	☐	High Blood Pressure	☐	Low Blood Pressure	☐
Phlebitis	☐	Pacemaker	☐	Congestive Heart Failure	☐
Heart Condition	☐	Description__________			

Respiratory Conditions

Shortness of Breath	☐	Asthma	☐	Emphysema	☐

Gastro-Intestinal System

Nausea	☐	Indigestion	☐	Bloating	☐
Constipation	☐	Diarrhea	☐		

Skin

Eczema	☐	Psoriasis	☐

Neurological System

Loss of Co-ordination	☐	Dizziness	☐	Multiple Sclerosis	☐
Loss of Sensation	☐	Stroke	☐	Epilepsy	☐

Genito-Urinary System

Cystitis	☐	Endometriosis	☐	Painful/Swollen Breasts	☐
PID	☐	Menopause	☐	Bladder	☐
Liver	☐	Gall Bladder	☐	Kidney	☐
Pregnancy	☐	Due Date ________________			

Psychological – Health & Well-Being

Depression	☐	Anxiety	☐	Stress Induced Condition	☐
Therapy	☐	Name of Therapist ________________________			

Other Conditions

Diabetes	☐	Hepatitis	☐	HIV/AIDS	☐
Hypoglycemia	☐	Hemophilia	☐	Allergies	☐
TB	☐				
Cancer	☐	When Diagnosed __________		Area Affected _____________	

Current Treatment ____

Activities of Daily Living

Type of work you do (i.e. sitting, standing, etc.) ______________________________________

Recreation/Physical Activities ____

Is your current condition limiting your choice of activities? ____________________________

Cancellation Policy

Time has been set aside for you. 24 hours notice is required if you need to cancel an appointment. A $50.00 cancellation fee will be charged for all missed appointments.

Confidential Health History

I understand that the information discussed during the assessment and treatment as well as the information I have provided on this form is accurate and strictly confidential and will not be released without my written permission. I will let my therapist know of any changes in my health status.

I _________________________________ consent to allow therapeutic massage. The treatment, probable outcomes, material risks, cost of treatment and cancellation policy has been explained to me. I appreciate that my consent may be revoked at any time during the treatment.

Signature _____________________________ Date _________________