Family Chiropractic & Massage Therapy advance

40 Queen Street N (Upper Level)
Bolton, ON L7E 1B9 ☎ 905-857-5411

Massage Health History Form

The information on this form is confidential and will be used for no other purpose than for the Therapist's clinical records. No information can be disclosed without written permission from the client, or if required by law.

Name		Occupation	
Address			
City/Province		Postal Code	
Primary phone # Home/Work/Cell (please circle)		Second phone # Home/Work/Cell (please circle)	
Email address: note this will only be used to provide appointment statements and reminders			
Date of Birth: Day_____ Month_____ Year_____		Sex: Male Female (please circle)	
Emergency Contact Name		Phone #	
Primary Care Physician Name		Phone #	
Massage Before Y/N	Chiropractic Y/N	Acupuncture Y/N	Other Therapies:

Who referred you for massage therapy or acupuncture?_____

What is the primary reason you are seeking massage therapy or acupuncture?

_____

Only complete if the answer to either option below is yes.

Is this a WSIB case? Yes/No Social Insurance Number _____ Date of Accident _____ Employers Name _____ Employers address & phone number	injuries related to a motor vehicle accident? Yes/No Date of Accident _____ Insurer's Name _____ Policy or Claim # _____ Insurer's address & phone number
Who else have you seen for this injury? MD Physio Massage Acupuncture Chiro	Who else have you seen for this injury? MD Physio Massage Acupuncture Chiro

Date of Initial Health History and Treatment _____ Update 1 _____ Update 2 _____ Update 3 _____

Please turn over and complete reverse side

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The information request below will assist us in treating you safely. Feel free to ask any questions about the information requested.

Cardiovascular
- ☐ High blood pressure
- ☐ Low blood pressure
- ☐ Poor circulation
- ☐ Chronic congestive heart failure
- ☐ Heart attack
- ☐ Phlebitis / varicose veins
- ☐ Stroke / CVA
- ☐ Pacemaker or similar device
- ☐ Heart disease

Family history of any of the above Y / N
(please note FH next to those applicable)

Respiratory
- ☐ Smoker
- ☐ Current / Past: When quit? _____
- ☐ Chronic cough
- ☐ Shortness of breath
- ☐ Bronchitis
- ☐ Asthma
- ☐ Emphysema
- ☐ Sinus infection
- ☐ Other breathing problem

Details:

Family history of any of the above Y / N
(please note FH next to those applicable)

Systemic conditions diagnosed by health care practitioner
- ☐ Epilepsy, onset _____
- ☐ Diabetes: Type I / II
- ☐ When diagnosed_____
- ☐ Cancer, where _____
- ☐ Arthritis, where _____
- ☐ Depression, mental illness
- ☐ Fibromyalgia
- ☐ Urinary disorders
- ☐ Kidney disorders
- ☐ Digestive disorders
- ☐ Liver disorders
- ☐ Osteoporosis

Family history of any of the above Y / N
(please note FH next to those applicable)

- ☐ Braces worn
  When_____ How long_____
- ☐ Retainer is it permanent Y / N
  On upper / lower teeth
- ☐ Night Guard

Women
- ☐ Menstrual problems
- ☐ Gynaecological condition _____
- ☐ Menopause: Peri Mid Post
- ☐ Pregnant: due _____
- ☐ Children Y / N number ____
  Birth: Vaginal / Cesarean

Head / Neck
- ☐ History of headaches
- ☐ History of migraines
- ☐ Vision problems
- ☐ Glasses / Contact Lenses
- ☐ Vision loss
- ☐ Ear problems / Earaches / Tubes
- ☐ Hearing loss

Infections
- ☐ Athlete's foot / Plantar Warts
- ☐ Hepatitis
- ☐ Tuberculosis
- ☐ Other respiratory infections _____
- ☐ HIV / AIDS
- ☐ Herpes
- ☐ Other _____

Other conditions
- ☐ Loss of sensation, where

- ☐ Skin condition (rosacea, eczema, etc)

Describe:

- ☐ Allergies/hypersensitivity to what

reaction

Any internal pins, wires, artificial joints or special equipment? Y / N
What and where? _____

Any fractures (broken bones)

Surgeries: When & what for

Injuries: When & what occurred

Current Medications	Conditions treated

Exercise (weights, cardio, organized sports): What and how often

Sleeping position, pillows used, issues sleeping, insomnia

Therapist Notes: