Family Chiropractic & Massage Therapy
advance

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

Massage & Acupuncture 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 self-care instructions (stretches & exercises).		
Date of Birth	Sex Male Female (please circle)	
Emergency Contact Name	Phone #	
Primary Care Physician Contact Name	Phone #	
Massage Before Y/N	Chiropractic 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	injuries related to a motor vehicle accident? Yes/No
Social Insurance Number _____	Date of Accident _____
Date of Accident _____	Insurer's Name _____
Employers Name _____	Policy or Claim # _____
Employers address & phone number	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 I 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: