Medical History Form

Last Name:_____ First Name:_____
Address:_____
City:_____ Province/State:_____
Postal Code/Zip:_____
Telephone: (home)_____ (work)_____ (cell)_____
Email Address:_____
Date of Birth: _____/_____/_____
dd mm yyyy

Occupation:_____ Company:_____

Current Health Status

Physician's Name:_____ Telephone#:_____

Primary Complaint:_____
_____
_____

Present Involvement in other health care (Chiropractic, Physiotherapy, etc.)
_____

Medications and reasons for use:_____
_____
_____
_____

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Past Surgeries and injuries:

Surgery/injury:	Date:	Treatment Received
_____	_____	_____
_____	_____	_____
_____	_____	_____

Medical History:

Cardiovascular
- Heart problems
- Hypertension
- Low blood pressure
- Circulatory problems
- CCHF
- Stroke/CVA
- Varicose veins
- Dizziness
- Chest pain

Respiratory
- Emphysema
- Asthma
- Chronic cough
- Bronchitis
- Difficulty breathing

Neurological
- Epilepsy
- Multiple Sclerosis
- Loss of Sensation
- Other

Muscles/joints
- Arthritis
- Osteoporosis
- Fracture/ dislocations
- Soft tissue injuries
- Fibromyalgia

Gastrointestinal
- Prolonged constipation
- IBS
- Chronic abdominal discomfort

Other
- Diabetes
- Cancer
- HIV/Aids
- Hepatitis
- Pregnancy
- Contagious Disease
- Seizures
- Allergies
- Local Skin Irritation
- Anaphylactic Shock

I, consent to the massage treatment as described by the Massage Therapist. I verify that the information given on this form is true and accurately reflects my past and present health status, and will inform therapist if my health status changes in the future.

APPOINTMENTS:

If you need to change your appointment, **a minimum of 24 hours is appreciated.** Otherwise, you may be billed personally for your missed appointment.

If you are late, your treatment will be shortened accordingly.

Client Signature:_____Date:_____