

# HEALTH HISTORY FORM – MASSAGE

Last Name:	First Name:	Date Of Birth (DDMMYYYY):	Gender <input type="radio"/> Male <input type="radio"/> Female
Address:		City:	Prov:
Postal Code:	Please take a moment to tell us how you heard about Quarry Chiropractic Clinic		
Telephone Home:	Work:	Ext:	Cell:
Occupation:	Physician Name and Address:	Physician contact number:	
Did a health care practitioner refer you for massage therapy? <input type="checkbox"/> YES <input type="checkbox"/> NO If yes please provide their name _____ Other: _____		Have you received massage therapy before? <input type="checkbox"/> YES <input type="checkbox"/> NO	

**GENERAL HEALTH INFO:** Please indicate conditions you are experiencing or have experienced

**Cardiovascular**

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

Is there a family history of any of the above?  Yes  No

**Respiratory**

- Chronic cough
- Shortness of breath
- Bronchitis
- Asthma
- Emphysema

Is there a family history of any of the above?  Yes  No

Are you currently receiving treatment from another health care professional?  YES  NO. If yes for what? \_\_\_\_\_

**Infections**

- Hepatitis
- Skin conditions
- TB
- HIV
- Herpes

**Other Conditions**

- Loss of sensation, where?  
\_\_\_\_\_
- Diabetes, onset: \_\_\_\_\_
- Allergies/hypersensitivity:  
\_\_\_\_\_
- type of reaction: \_\_\_\_\_
- Skin conditions: \_\_\_\_\_
- \_\_\_\_\_
- Cancer, where?  
\_\_\_\_\_
- Arthritis

Is there a family history of any of the above?  Yes  No

Other medical concerns: \_\_\_\_\_  
 \_\_\_\_\_

**Head/Neck**

- History of headaches
- History of migraines
- Vision problems
- Vision loss
- Hearing loss
- Ear problems

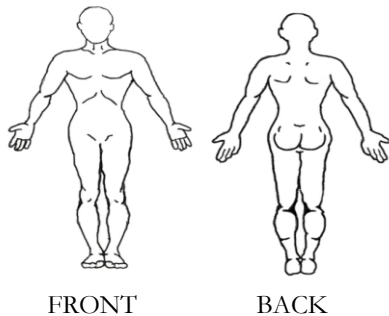
**Women**

- Gynaecological conditions  
\_\_\_\_\_
- Pregnant  
How many months: \_\_\_\_\_
- Past surgeries: \_\_\_\_\_
- \_\_\_\_\_
- Current Medications: \_\_\_\_\_
- \_\_\_\_\_
- Condition it treats: \_\_\_\_\_
- \_\_\_\_\_

Do you have any internal pins, wires, artificial joints, or special equipment?  YES  NO  
 What? \_\_\_\_\_  
 Where? \_\_\_\_\_

**AREAS OF CONCERN: Primary complaint:** \_\_\_\_\_  
**Secondary complaint:** \_\_\_\_\_

Please indicate location of any muscular, joint or tissue discomfort on the diagram. Use the symbols to determine the type of discomfort or pain you are feeling.



**Symbols**

Pins, Needles or Numbness ●●●●●●

Dull Ache ~~~~~~

Stiff & Tight //////////////

Burning XXXXXX

**To Be Signed By the Client:** I acknowledge that the above information is accurate and complete at this time. I understand that written and verbal consent will be ongoing. I also understand that I can alter or rescind my consent at any time during this and any treatment. I understand that during a massage if necessary the areas that might need to be worked on include: chest wall muscles, inner thigh muscles, and gluteal (buttocks) muscles. At this time I am voluntarily giving my consent for treatment.

Date: \_\_\_\_\_ Name: \_\_\_\_\_ Signature: \_\_\_\_\_

Parent/Guardian signature (if under 16 years old): \_\_\_\_\_