CLINIC 1801 Dundas St. E, Whitby
PHONE 905-240-6566
FAX 905-240-6466
EMAIL physoicarewhitby@yahoo.ca

Health History Form

The information requested below will assist us in treating you safely. Feel free to ask any questions about the information that is being requested. Please note that all information provided is kept confidential unless allowed or required by law. Your written permission will be required to release any information.

Name: _____ Phone #:_____
Address: _____
Occupation: _____ Date Of Birth: _____

Have you received massage therapy before? Yes ☐ No ☐

Did a health care practioner refer you for massage therapy? Yes ☐ No ☐

If yes, Please provide their name and address: _____

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/CVA
- ☐ Pacemaker/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 □

Infections

- ☐ Hepatitis
- ☐ Skin Conditions
- ☐ TB
- ☐ HIV
- ☐ Herpes

Other Conditions

- ☐ Loss of Sensation

If yes, Where? _____

- ☐ Diabetes, onset _____
- ☐ Allergies/Hypersensitivity

If yes, To what? _____

_____

- ☐ Epilepsy
- ☐ Cancer

If yes, Where? _____

- ☐ Skin Conditions

If yes, what Kind? _____

_____

- ☐ Arthritis

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

Head/Neck

- ☐ History of Headaches
- ☐ History of Migraines
- ☐ Vision Problems
- ☐ Vision Loss
- ☐ Ear Problems
- ☐ Hearing Loss

Women

- ☐ Pregnant

If yes, Due: _____

- ☐ Gynaecological conditions

If yes, what Kind? _____

_____

Overall, How is your general health?

_____

_____

Primary Care Physician:

_____

Address: _____

_____

Notes: _____

_____

_____

_____

_____

_____

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Current Medications: _____
_____

Condition it Treats: _____
_____

Are you currently receiving treatment from another health care professional? Yes □ No □
If yes, for what? _____
_____

Surgery
Nature:_____
_____

Injury Nature: _____
_____

Do you have any other medical conditions? (e.g. digestive conditions, haemophilia, osteoporosis, mental illness)
Yes □ No □ If yes, what Kind?
_____
_____

Do you have any internal pins, wires, artificial joints, or special equipment? Yes □ No □
If yes, what Kind?
_____

What is the reason you are seeking massage therapy? Please include the location of any tissue or joint discomfort.
_____
_____
_____

Date of Initial Health History: _____
Update 1 _____
Update 2 _____
Update 3 _____
Update 4 _____