BELMONT NATURAL HEALTH CENTRE

HEALTH HISTORY FORM (PLEASE PRINT)

***** PLEASE ENSURE YOU SIGN AND DATE THE BACK OF THIS FORM UPON COMPLETION *****

CONTACT INFORMATION

First name:	Last name:
Phone number:	Email address: Do you give permission for us to contact you by email? ☐ Yes ☐ No
Address:	

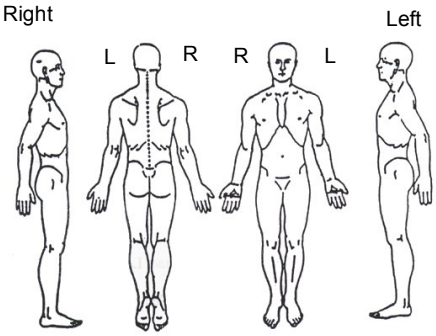
Occupation:	Date of birth:	Age:
Name of family doctor:	Doctor's address:	Doctor's phone number:
Emergency contact:	Emergency contact's phone number:	

How did you hear about our clinic?

HEALTH INFORMATION

Please circle your perception of your general health: **(poor) 1 – 2 – 3 – 4 – 5 (excellent)**

What is the health concern that you hope to address with massage therapy **today**?



Please circle on the image to the left where you are experiencing any pain, stiffness, numbness and/or tingling:

Please circle the severity of your pain:

(no pain) 0 – 1 – 2 – 3 – 4 (stubbed toe) – 5 – 6 – 7 – 8 – 9 – 10 (worst pain ever)

When did you first experience this health concern?

Was there an injury or change in life style that you associate with the beginning of this health concern? ☐ Yes ☐ No
If yes, what was it?

Does this condition limit your activities of daily living? ☐ Yes ☐ No
If yes, how so?

Aggravating factors (what makes it worse):	Relieving factors (what makes it better):

Are you **currently** receiving treatment from another health care provider? ☐ Yes ☐ No

☐ Naturopathic doctor ☐ Physiotherapist ☐ Chiropractor ☐ Other: _____

Did a health care provider recommend massage therapy? ☐ Yes ☐ No

Have you had massage therapy previously? ☐ Yes ☐ No

DO YOU HAVE A HISTORY OF AND/OR ARE YOU CURRENTLY EXPERIENCING ANY OF THE FOLLOWING (CHECK ALL OF THE BOXES IN THE LISTS BELOW THAT APPLY):

Cardiovascular	Head and Neck	Infectious Conditions	Respiratory
☐ High blood pressure ☐ Low blood pressure ☐ Chronic congestive heart failure ☐ Heart disease/heart attack ☐ Varicose veins or phlebitis ☐ Poor circulation ☐ Swelling in ankles ☐ Stroke/CVA ☐ Pacemaker or similar device ☐ Dizziness/vertigo ☐ Seizures	☐ Headaches ☐ Migraines ☐ Vision problems ☐ Vision loss ☐ Ear problems ☐ Hearing loss	☐ Skin conditions ☐ Respiratory conditions ☐ Hepatitis Type: ____ ☐ HIV ☐ Herpes ☐ TB	☐ Asthma ☐ Bronchitis ☐ Emphysema ☐ Chronic cough ☐ Shortness of breath

Muscle/Joint Pain/Stiffness/Weakness	Digestive	Other
☐ Neck ☐ Back – lower ☐ Back – mid ☐ Back – upper ☐ Shoulders ☐ Upper arm ☐ Lower arm ☐ Wrist/hand ☐ Hip ☐ Knee ☐ Ankle/foot	☐ Indigestion or heartburn ☐ Constipation ☐ Diarrhea ☐ Crohn's disease ☐ Colitis ☐ Irritable bowel syndrome ☐ Ulcers ☐ Diverticulitis	☐ Loss of sensation ☐ Diabetes ☐ Epilepsy ☐ Cancer ☐ Allergy/hypersensitivity ☐ Hemophilia ☐ Fibromyalgia ☐ Chronic fatigue ☐ Sciatica ☐ Arthritis ☐ Osteoarthritis ☐ Degenerative disc disease ☐ Bursitis ☐ Scoliosis ☐ Polio/post-Polio ☐ Osteoporosis ☐ Mental health condition ☐ Insomnia

Do you have a family history of any of the conditions listed above (please list below):

Previous injuries/surgeries/serious illnesses:

Do you have any of the following? ☐ Artificial joints ☐ Internal pins plates or wires ☐ Special equipment

Location(s): _____

Please list below all medication(s) you are currently taking and the condition(s) they are treating:

Medication/Supplements	Please note any other medications you are currently taking that are not listed **and what they address**:
☐ Anti-inflammatories ☐ Analgesics ☐ Antibiotics ☐ Blood pressure medication ☐ Heart medication/Blood thinners ☐ Depression/anxiety ☐ Muscle relaxants ☐ Vitamins/Herbs	_____ _____ _____ _____

Are you currently pregnant?	☐ Yes ☐ No	Trimester: ☐ One ☐ Two ☐ Three
Do you have any menstrual or menopausal concerns?	☐ Yes ☐ No	
Have you taken any anti-inflammatory medication, pain killers, muscle relaxants or mood altering medication within the past two hours?	☐ Yes ☐ No	
Have you traveled abroad within the last month?	☐ Yes ☐ No	
Have you experienced flu-like symptoms in the past two weeks?	☐ Yes ☐ No	
During treatment, do you prefer minimal conversation?	☐ Yes ☐ No ☐ No preference	
Do you tend to prefer more pressure or less pressure?	☐ More ☐ Moderate ☐ Less ☐ Unsure	
What are your treatment expectations?	☐ Relaxation ☐ Therapeutic (associated with specific injury or condition) ☐ Both	

Any additional comments?

_____

_____

_____

I attest that the information provided here is complete and correct to my knowledge and I understand that it is my responsibility to inform my therapist if there are any changes to my health. The information requested here will assist us in treating you safely, feel free to ask any questions about the information requested. Please note that all information provided will be kept confidential unless given your written consent or required by law.

PATIENT/GUARDIAN/SUBSTITUTE DECISION MAKER SIGNATURE:	**DATE (YEAR/MONTH/DAY):**