

Jeremy Bissonnette *Registered Massage Therapist*

HEALTH HISTORY FORM

For your information:

An accurate health history is important to ensure that it is safe for you to receive a massage treatment. If your health status changes in the future, please let me know. All information gathered for this treatment is confidential except as required or allowed by law or except to facilitate diagnosis (assessment) or treatment. You will be asked to provide written authorization for release of any information.

Name: _____ Date: _____

Tel: _____ res _____

Address: _____ bus _____

Fax/email _____

Date of birth: _____ Occupation: _____ What is your primary complaint? _____

Who referred you? _____ Their address? _____

Health History: ! Please indicate conditions you are experiencing, or have experienced:

Respiratory	Other Conditions	Women
<input type="checkbox"/> chronic cough <input type="checkbox"/> shortness of breath <input type="checkbox"/> bronchitis <input type="checkbox"/> asthma <input type="checkbox"/> emphysema	<input type="checkbox"/> loss of sensation <input type="checkbox"/> diabetes (onset: _____) <input type="checkbox"/> allergies (ie. anaphylaxis or skin irritation) <input type="checkbox"/> epilepsy <input type="checkbox"/> cancer <input type="checkbox"/> arthritis	<input type="checkbox"/> pregnant (due: _____)
Cardiovascular	Head/Neck	Soft tissue/joint discomfort and its nature
<input type="checkbox"/> high blood pressure <input type="checkbox"/> low blood pressure <input type="checkbox"/> CCHF <input type="checkbox"/> heart attack <input type="checkbox"/> phlebitis <input type="checkbox"/> stroke/CVA <input type="checkbox"/> pacemaker or similar device <input type="checkbox"/> heart disease	<input type="checkbox"/> vision problems <input type="checkbox"/> vision loss <input type="checkbox"/> ear problems <input type="checkbox"/> hearing loss	<input type="checkbox"/> neck _____ <input type="checkbox"/> low back _____ <input type="checkbox"/> mid back _____ <input type="checkbox"/> upper back _____ <input type="checkbox"/> shoulders _____ <input type="checkbox"/> arms _____ <input type="checkbox"/> legs _____ <input type="checkbox"/> knees _____ <input type="checkbox"/> other _____
Skin	Infections	What is your general health status? _____
<input type="checkbox"/> skin conditions	<input type="checkbox"/> hepatitis <input type="checkbox"/> skin conditions <input type="checkbox"/> TB <input type="checkbox"/> HIV	

Current Medications: _____

Condition it treats: _____

Surgery: _____ date: _____

nature: _____

Injury: _____ date: _____

nature: _____

Primary Care Physician: _____

Address: _____

Present Involvement in Other Health care:

Yes No

If yes, please specify: _____

Other Medical Conditions (e.g. digestive conditions, gynaecological conditions, hemophilia, etc.): _____

Of Special Note: (presence of internal pins, wires, artificial joints, special equipment): _____

