Confidential Patient Health History Form

THE STUDY
Wellness Studio

Name:_____ o Male o Female

Address:_____ City:_____ Prov:_____

Postal code:_____ Home Phone:_____ Work Phone:_____

Birth Date:(m)_____ (d)_____ (y)_____ Occupation:_____

Medical Doctor:_____ Doctors phone #:_____

How did you hear about us?_____

Please indicate conditions you are experiencing or have experienced:

*Check all applicable

Cardio Vascular

- o High Blood Pressure
- o Low Blood Pressure
- o Chronic congestive heart failure
- o Heart Attack
- o Phlebitis/Varicose Veins
- o Stroke/CVA
- o Pacemaker or similar device
- o Heart Disease
- o Dizziness/vertigo
- o Seizures

Is there a family history of any of the above?

- o Yes o No

Respiratory

- o Asthma
- o Bronchitis
- o Emphysema
- o Chronic Cough
- o Shortness of breath

Is there a family history of any of the above?

- o Yes o No

Digestive

- o Constipation
- o Chrones Disease
- o Colitis
- o Irritable Bowel Syndrome
- o Ulcers

Head and Neck

- o History of headaches
- o History of migraines
- o Vision Problems
- o Vision loss
- o Ear Problems
- o Hearing loss

Women

- o Pregnancy
  Due Date:_____.
- o Previous pregnancy complications
- o Menopausal problems
- o Gynecological conditions
  Describe:

Muscle/Joint

- o Neck
- o Back (lower)
- o Back (middle)
- o Back (upper)
- o Shoulders
- o Elbow
- o Wrist/Hand
- o Hip
- o Knee
- o Ankle/Foot
- o Spine

Infectious Conditions

- o Skin Conditions

Describe:

- o Respiratory Conditions
  Describe:
- o Hepatitis

Skin Conditions

- o Eczema
- o Psoriasis
- o Rash
- o Warts
- o Open Sores

Other

- o Loss of sensation
  Where?_____.
- o Diabetes
  Onset:
  Type:
- o Allergies/hypersensitivity
  What?
- o Epilepsy
- o Cancer
  Type/Location:
- o Arthritis
  Is there a family history of arthritis?
  o Yes o No
- o Hemophilia
- o Fibromyalgia
- o Chronic fatigue
- o Scoliosis
- o Polio/Post Polio
- o Osteoporosis

Men

- o Enlarged Prostate
- o Other:_____.

Do you have any medical conditions not listed above? o Yes o No

*If yes, please describe:*_____

Do you have any internal wire, artificial joints, pacemakers or special equipment that we should be aware of?

o Yes o No *If yes please describe:*_____

Please circle areas that are currently causing you symptoms of pain, stiffness, numbness or other forms of discomfort:

Face	Upper back	Arm(s)	Hand(s)	Thigh(s)	Ankle(s)	Neck
Mid back	Elbow(s)	Finger(s)	Knee(s)	Foot/Feet	Shoulder(s)	Lower back
Wrist(s)	Hip(s)	Leg(s)	Toes(s)	Chest	Ribs	Tailbone

For what condition or reason are you seeking treatment today?_____

_____

Have you seen any other health care professional(s) for this condition or reason? o Yes o No

If yes whom?_____

Have you ever been involved in any motor vehicle accidents? o Yes o No Date:_____

Have you been involved in any other accidents? o Yes o No Date:_____

Have you ever been knocked unconscious? o Yes o No Date:_____

List any surgeries you have undergone, for what and when:

_____

_____

Are you presently taking any prescribed medication(s)? o Yes o No
If yes, please list the medication(s) and the condition(s) for which it is being used:

_____

_____

Have you previously received massage therapy treatments? o Yes o No
If yes, were you treated: *o* **At this clinic** **o From an RMT** **o Other**

Please circle on the following scales the extent to which you are currently satisfied with the following:
(5 represents total satisfaction, 1 represents little or no satisfaction)

Physical health & fitness	5	4	3	2	1
Mental & emotional happiness	5	4	3	2	1
Energy Level	5	4	3	2	1
Diet	5	4	3	2	1
Ability to relax	5	4	3	2	1

I acknowledge that the Massage Therapist is not a physician and does not diagnose illness or disease or any other physical or mental disorder. I clearly understand that massage therapy is not a substitute for a medical examination. It is recommended that I attend my personal physician for any ailment that I may be experiencing. I acknowledge that no assurance or guarantee has been provided to me as to the results of the treatment.

I acknowledge and understand that the Massage Therapist must be fully aware of my existing medical conditions. I have completed my medical history form as provided by my Massage Therapist and disclosed all of those medical conditions affecting me. It is my responsibility to keep the Massage Therapist updated on my medical history. The information I have provided is true and complete to the best of my knowledge.

Print name (clearly)	*Signature*	*Date*
Practitioner name	*Signature*	*Date*