

Health History Form

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

Name: _____ Date: _____
Phone (Home) _____ (Cell Phone) _____ (Work) _____
Address _____ Postal Code _____
Occupation: _____ Date of Birth: _____
Email (for reminder calls) _____
Have you received massage therapy before? Yes No
Who referred you to our clinic? _____
Please indicate conditions you are experiencing or have experiences:

Cardiovascular

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

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, where?

Diabetes, onset: _____

Allergies/ hypersensitivity to what?

Type of reaction: _____

Epilepsy

Cancer, where? _____

Skin conditions, what?

Arthritis, what type?

Is there a family history of arthritis?
 Yes No

Head/ Neck

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

Women

Pregnant, due _____

Gynaecological conditions,
What? _____

Overall, how is your health?

Primary Care Physician:

Address _____

Phone# _____

Current Medications:

Conditions it treats: _____

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

Surgery- date _____
Nature: _____

Injury – date _____
Nature: _____

Do you have any other medical conditions? (e.g. digestive conditions, haemophilia, osteoporosis, mental illness) Yes No
What? _____

Do you have any internal pins, wires, artificial joints or special equipment? Yes No
What? _____
Where? _____

What is the reason you are seeking massage therapy?
Please include the location and if there is any joint discomfort.

Pickering Chiropractic Health Centre

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