OAKVILLE CHIROPRACTIC & FAMILY HEALTH

Oakville Chiropractic and Family Health
2525 Old Bronte Road, Suite # 380
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Massage Health History Form

An accurate health history ensures that it is safe for you to receive a massage treatment, and helps the therapist determine a proper treatment plan. Please let us know if your health status changes in the future. All information gathered on this form is confidential. Your written authorization is legally required before any of this information can be released, unless required by law.

Name:_____ Email:_____Cell Phone:_____

Address: _____ Home Phone:_____

Occupation: _____ Birthdate (mm/dd/yy): ___/___/___ Height:_____Weight: _____

Have you had a massage before: ☐ Y ☐ N *For relaxation or other reason?*_____

Please indicate if you are experiencing or have experienced any of the following conditions:

Cardiovascular

- ☐ High blood pressure
- ☐ Low blood pressure
- ☐ Chronic congestive heart failure
- ☐ Heart attack, when: _____
- ☐ Phlebitis/varicose veins
- ☐ Stroke
- ☐ Pacemaker
- ☐ Heart disease
- ☐ Family history of the above?

Respiratory

- ☐ Chronic cough
- ☐ Shortness of breath
- ☐ Bronchitis
- ☐ Asthma
- ☐ Emphysema
- ☐ Pneumonia
- ☐ Family history of the above?

Infections

- ☐ Hepatitis
- ☐ Skin conditions,
- ☐ What? _____
- ☐ Tuberculosis
- ☐ HIV
- ☐ Herpes
- ☐ Family history of the above?

Other Conditions

Loss of sensation, where?

_____

Allergies/hypersensitivity, to what?

_____

Diabetes, onset: _____
Arthritis , onset: _____
Cancer, where? _____
Family history of the above?
What? _____

Head/Neck

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

Spine

- ☐ Herniated disc
- ☐ Scolioisis
- ☐ Spondylosis

Women

Pregnant, due date: _____
Gynaecological conditions, _____
What? _____

Describe your health overall: _____

Primary Medical Doctor: _____

_____

Current Medications:

_____

Condition it treats:

_____

Are you receiving other professional health care? If so, please explain:

_____

Previous surgeries, major illness, MV accidents (include date): _____

_____

Do you have any other medical conditions? (e.g.m, digestive conditions, blood conditions, osteoporosis, mental illness). Please explain:

_____

Do you have any internal pins, rods, artificial joints? If so, what?

_____

What is the reason you are seeking massage therapy? Include location and type of discomfort:

_____

I have read and understand the above. I hereby give consent for treatment/assessment by a Registered Massage Therapist.

Signature: _____ Date: _____