McAllister Chiropractic and Massage

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MASSAGE THERAPY - Health History Form

WELCOME TO OUR OFFICE – The information requested below will assist us in treating you safely. Feel free to ask any questions about the information being requested. Please note that all information below will be kept confidential unless allowed or required by law. Your written permission will be required to release any information.

First Name	Surname	Date

Address	Apt #	City	Postal Code

Tel # (home)	Tel # (work including extension)	Tel # (cell)

Date of Birth (DD / MM / YYYY)	Age:	Have you ever received massage therapy before? ☐ Yes ☐ No	Have you ever had major surgery? ☐ Yes ☐ No Date: & Nature:

Occupation:	How did you find out about our office?	Have you recently been injured? ☐ Yes ☐ No When: & Where:

Did a health care practitioner refer you for massage therapy? ☐ Yes ☐ No	Medical Doctor's Name:	Medical Doctor's Address:

Please indicate the conditions you are experiencing or have experienced:

Cardiovascular
- ☐ High Blood Pressure
- ☐ Low Blood Pressure
- ☐ Chronic Congestive Heart Failure
- ☐ Heart Attack
- ☐ Phlebitis / Varicose Veins
- ☐ Pacemaker or Implanted Defibrillator
- ☐ Heart Disease

Is there a family history of any of the above?
☐ No ☐ Yes

Respiratory
- ☐ Chronic Cough
- ☐ Shortness of Breath
- ☐ Bronchitis
- ☐ Asthma
- ☐ Emphysema

Is there a family history of any of the above?
☐ No ☐ Yes

Infections
- ☐ Hepatitis
- ☐ Skin Conditions
- ☐ Tuberculosis (TB)
- ☐ HIV
- ☐ Herpes

Head / Neck
- ☐ History of Headaches
- ☐ History of Migraines
- ☐ Vision Problems
- ☐ Vision Loss
- ☐ Ear Problems
- ☐ Hearing Loss

Women
- ☐ Pregnant, due: ____________
- ☐ Gynecological conditions, what? ____________

Other Conditions
- ☐ Loss of sensation, where? ____________
- ☐ Diabetes, onset: ____________
- ☐ Allergies or hypersensitivity to: ____________

  Type of reaction: ____________
- ☐ Epilepsy
- ☐ Cancer, where? ____________
- ☐ Skin conditions, what? ____________
- ☐ Arthritis

Is there a family history of arthritis?
☐ No ☐ Yes

Over all, how is your general health?

Please list any current medications — Conditions they treat:

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

Do you have any internal pins, wires, artificial joints or special equipment? ☐ No ☐ Yes — What and where?

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

What is the reason you are seeking massage therapy?
Please include the location of any tissue or joint discomfort.

Notes:

	Date	Initial
Initial Health History:		
Update 1:		
Update 2:		
Update 3:		
Update 4:		