New Hamburg Wellness Centre

PATIENT HEALTH HISTORY

NOTE: *An accurate health history is important to ensure that it is safe for you to receive a massage treatment. Please inform your therapist if your health status changes in the future. The information gathered in this form is considered strictly confidential. Your responses are important to help us better understand the health issues you face and ensure the delivery of the best possible treatment.*

NAME: _____ **TODAY'S DATE:** _____

ADDRESS: _____

_____ **POSTAL CODE:** _____

PHONE NUMBER: (HOME)_____ **(WORK)**_____**EXT.** _____

(CELL) _____ **DATE OF BIRTH: M**_____**D**_____**Y**_____ **SEX: M F**

OCCUPATION: _____ **EMPLOYER:** _____

EMAIL ADDRESS: _____

EMERGENCY CONTACT: _____ **PHONE #:** _____

HOW DID YOU HEAR ABOUT OUR CLINIC? _____

HAVE YOU PREVIOUSLY RECEIVED MASSAGE THERAPY? YES _____ **NO** _____

IF YES, WHEN WAS YOUR LAST TREATMENT? _____

Please give a brief description of the problem(s) you are currently experiencing: _____

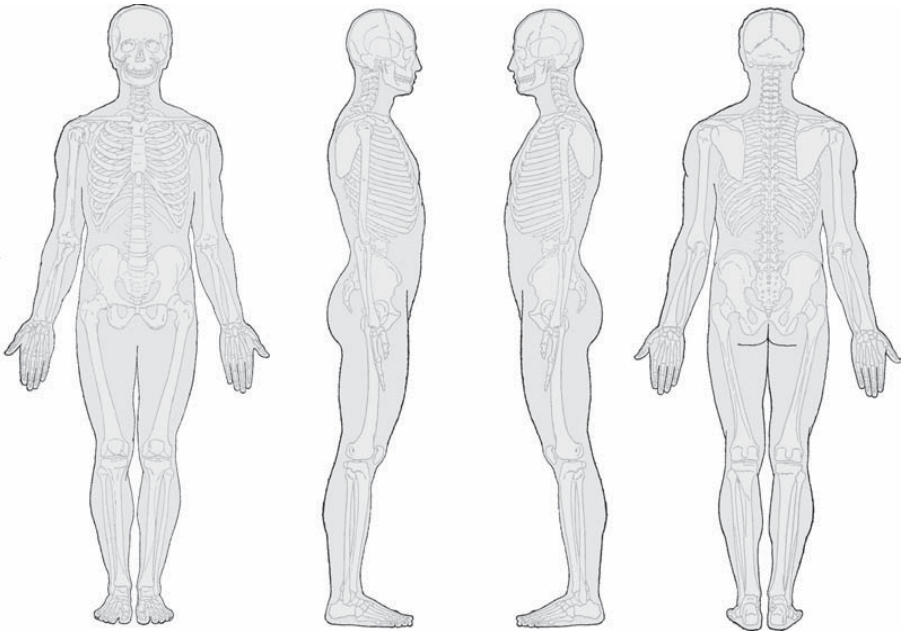
_____

What seemed to be the initial cause? _____

How long have you had this condition? _____ Is it getting worse? □ Yes □ No _____

What activities, factors or positions aggravate your signs and symptoms? _____

What if anything have you found to relieve or improve your signs and symptoms? _____



On the diagram, please indicate the area(s) of your chief complaint(s) using the symbols provided:

Numbness	= = =
Pins & needles	# # #
Burning	x x x
Sharp & stabbing	/ / / /
Dull & aching	+ + +
Stiff & tight	2 2 2

Please indicate below the severity of any discomfort or any pain you feel now:

(0) **(10)**

Minimal ·__·__·__·__·__·__·__·__·__·__· Extreme

Please indicate conditions you are experiencing or have experienced:

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

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, 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 general health? _____

Primary Care Physician: _____

Address & Phone Number: _____

_____

Current Medications: _____
_____

Condition 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? _____

Notes:

Date of Initial Health History: _____
Update 1: _____
Update 2: _____
Update 3: _____

Our centre is committed to conforming to federal privacy legislation effective January 1, 2004. All information collected is kept strictly confidential, unless the release of this personal information is authorized by yourself, the undersigned, or is required by law. I, the undersigned, believe that all information on this form is true to the best of my knowledge.

Signature: _____ **Date:** _____