Courtyard Chiropractic
Health Centre
Inspiration, Dedication & Experience
Celebrating your wellness since 1997

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Confidential Health History Form - Massage Therapy

The information contained on this form will be kept confidential and will be used for no other purpose than for your therapist's clinical record. Should any of the information change, please provide us with details in order to provide you with optimum health care. Thank you.

Name: ____ **M** **F** Date:________________

Address:____________________________ City/Province:___________ Postal Code:____________

Home #:______________________ Cell #:_________________ Business #:___________________

Email Address:____________________________ How did you hear about us: _________________

Date of Birth (M/D/Y):___________ Occupation:__________________ Hobbies:_______________

Emergency Contact:____________________________________ Phone:______________________

Medical Doctor:____________________________ Address & Phone:__________________________

How would you rate your current health?: ____

How would you rate your activity level?: **Sedentary** **Light** **Medium** **Athletic**

What are your goals/reasons for seeking massage therapy?___________________________________

Please list **medications/supplements** and the conditions they treat:_____________________________

____

Do you have any known **allergies**:____

Are you in pain or discomfort: **Yes** **No** If yes, please describe (location, intensity, quality, etc.)

____

If no, please indicate any other symptoms (stiffness, numbness, etc.) _________________________

Are you under care of any other types of health care professionals?_____________________________

Please list any surgeries, injuries or hospitalizations:

____

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____

Do you use any assistive devices (cane, walker, hearing aid, etc.)?_______________________________

For Office Use Only (Updates)

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PLEASE INDICATE ANY APPLICABLE CONDITIONS / SYMPTOMS

(Current and Previous) Please indicate Previous with the letter "P"

Head and Neck:

__ Headaches
__ Migraines
__ Poor Vision
__ Hearing Loss
__ Glasses / Contact Lenses
__ Jaw/Dental Problems
__ Whiplash
__ Brain Injury / Concussion
__ Other___________

Digestive/Urinary Disorders:

__ Constipation
__ Irritable Bowel Syndrome
__ Diabetes Type I or Type II
__ Gall Bladder / Liver
__ Difficult Digestion
__ Ulcers
__ Hiatus Hernia
__ Diarrhea
__ Kidney / Urinary Bladder
__ Other___________

Joint & Muscle:

__ Neck
__ Upper Back
__ Mid Back
__ Lower Back
__ Shoulder
__ Hip
__ Knee
__ Arm / Hand
__ Feet
__ Other___________

Cardiovascular:

__ High Blood Pressure
__ Low Blood Pressure
__ Heart Disease
__ Varicose Veins
__ Heart Attack
__ Stroke
__ Pacemaker
__ Poor Circulation
__ Other___________

Skin Conditions:

__ Psoriasis
__ Eczema
__ Rashes / Acne
__ Sensitivity / Numbness
__ Bruise Easily
__ Plantar Warts
__ Frostbite
__ Other___________

Female:

__ Painful Periods
__ Pregnancy
due date:___________
__ Menopause
__ Yeast Infections
__ Other___________

Respiratory:

__ Asthma
__ Chronic Cough
__ Shortness of Breath
__ Bronchitis
__ Emphysema
__ Allergies/Sinusitis
__ Smoker
__ Sleep Apnea
__ Other___________

Infectious Conditions:

__ Tuberculosis
__ AIDS/HIV
__ Hepatitis
__ Infectious Skin Conditions
__ Other___________

Diseases/Conditions:

__ Cancer
__ Fibromyalgia
__ Osteoporosis
__ Scoliosis
__ Carpal Tunnel
__ Multiple Sclerosis
__ Arthritis
__ Family History of Arthritis

This is to confirm and acknowledge that this information is correct and accurate to my knowledge and I give my consent for treatment by a Registered Massage Therapist.

[ ] I accept **appointment e-reminders**, statements and other e-communication, and understand I can unsubscribe any time.
[ ] No emails at all.
For more information, please refer to our Privacy Policy or Contact us for more details.

Signature:____**Date:** __________________