Hands on Health
Family Chiropractic

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Health History Form

Please understand that an accurate health history is important to ensure that it is safe for you to receive a massage treatment. Should your health status differ from this form, it is imperative that you inform your therapist as soon as possible. All information gathered for this treatment is confidential, except as required or allowed by law, or except to facilitate diagnosis (assessment) or treatment. You will be asked to provide written authorization for release of any information. PLEASE NOTE: 24 HOURS NOTICE IS REQUIRED TO CANCEL OR CHANGE A MASSAGE APPOINTMENT. A fee of $25 will be charged to the client if less than 24 hours notice is provided.

Please complete this form to the best of your knowledge.

Name _____ Date _____
Address _____
_____
Phone: home _____ business _____
Email _____ cell phone _____
Occupation _____

Date of Birth _____ Physician _____
Physician location/phone _____
Medications _____
Conditions _____

Primary complaint _____
Name of referral _____

Please indicate by circling or checking conditions you are currently experiencing or you have experienced.

Respiratory
- chronic cough
- shortness of breath
- bronchitis
- asthma
- emphysema

Cardiovascular
- high blood pressure
- low blood pressure
- CCHF
- heart attack
- phlebitis
- stroke/CVA
- pacemaker or similar devices

Skin
- skin conditions

Other Conditions
- loss of sensation
- diabetes (onset:_____)
- allergies (type:_____)
- epilepsy
- cancer
- arthritis
- osteoporosis

Head/Neck
- vision problems
- vision loss
- ear problems
- hearing loss

Infections
- Hepatitis
- TB
- HIV

Women
- pregnant
- due:_____

Soft Tissue and Joint Discomfort
- neck
- upper back
- mid back
- lower back
- shoulders
- arms
- legs
- knees
- spine
- other

General Health
_____

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Life Style
- exercise regularly
- alcohol and/or drugs
- caffeine
- smoke
- Other

Other Treatments
- Chiropractic
- Physiotherapy
- Reflexology
- Homeopathy
- Other

Past surgeries or injuries

Surgery /Injury	Date	Treatment Received
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Additional Comments/Concerns _____

_____

_____

The above information is complete and accurate to the best of my knowledge. Any future changes to my health status will be communicated to the therapist previous to treatment.

Signature: _____ **Date:** _____

Date	Update (additional info complimenting the medical history form)
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____