Kingswood Massage Therapy

— 1210 Hammonds Plains Rd., Bedford, N.S. B4B 1B4 Tel: (902) 832-1411 ----------

MEDICAL HISTORY FORM

(please print)

LAST NAME _____ FIRST NAME _____ MIDDLE INITIAL _____

DATE OF BIRTH (M/D/Y) _____ SEX/GENDER _____ AGE _____

ADDRESS _____ CITY, PROVINCE _____ POSTAL CODE _____ TEL # (__)_____

OCCUPATION _____ EXTRACURRICULAR ACTIVITIES _____

DOCTOR _____ ADDRESS _____ TEL # (__)_____

EMERGENCY CONTACT _____ RELATIONSHIP _____ TEL # (__)_____

PERSONAL HEALTH HISTORY AND/OR USAGE:

CIGARETTES	__YES	__ NO	IF YES, # OF TIMES/WEEK	_____
ALCOHOL	__YES	__ NO	IF YES, # OF TIMES/WEEK	_____
CAFFEINE	__YES	__ NO	IF YES, # OF TIMES/WEEK	_____
DRUGS	__YES	__ NO	IF YES, # OF TIMES/WEEK	_____
EXERCISE	__YES	__ NO	IF YES, # OF TIMES/WEEK	_____

PLEASE INDICATE (√) IF YOU HAVE A HISTORY WITH ANY OF THE FOLLOWING:

• CARDIOVASCULAR
- __ C.V.A (STROKE)
- __ HIGH BLOOD PRESSURE
- __ LOW BLOOD PRESSURE
- __ CHRONIC CONGESTIVE HEART FAILURE
- __ VARICOSE VEINS
- __ CHEST PAIN
- __ DIZZINESS

• MMS/JOINTS
- __ ARTHRITIS
- __ OSTEOPOROSIS
- __ MUSCLES WEAK
- __MUSCLES SORE
- __ OTHER

(SPECIFY)__ _____

• RESPIRATORY
- __ ASTHMA
- __ CHRONIC COUGH
- __ EMPHYSEMA
- __ BRONCHITIS
- __ OTHER

(SPECIFY)_____

• OTHER CONDITIONS
- __ CANCER
- __ HIV/AIDS
- __ DIABETES
- __ HEPATITIS
- __ PREGNANCY
- __ OTHER

(SPECIFY)_____

• NEUROLOGICAL
- __ MULTIPLE SCLEROSIS
- __ EPILEPSY
- __ ANY LOSS OF SENSATION
- __ OTHER

(SPECIFY)_____

• ALLERGIES (PLEASE STATE BELOW)

_____
_____
_____
_____

FORM CONTINUED ON BACK

MEDICATIONS	REASONS FOR USE

PLEASE LIST PAST SURGERIES/INJURIES:

SURGERY/INJURY	DATE	TREATMENT RECEIVED

- **PRIMARY REASON FOR TODAYS VISIT** _____
- **OTHER ON-GOING/RECURRING PROBLEMS** _____
- HOW DID YOU HEAR OF THE MASSAGE THERAPIST AT THIS CLINIC? _____

AUTHORIZATION FOR TREATMENT (if patient is over 18 years of age)

I, _____do hereby give consent for Massage Therapy treatment and verify that the information given on this form is true and accurately reflects my past and present health status.

_____

SIGNATURE OF PATIENT DATE

AUTHORIZATION FOR TREATMENT (if patient is under 18 years of age)

I, _____do hereby give consent, authorize, and request Massage Therapy treatment for my daughter/son and verify that the information given on this form accurately reflects my daughter/sons past and present health status.

_____

SIGNATURE OF PARENT/GUARDIAN DATE

PLEASE DO NOT FILL OUT BELOW

MEDICAL HISTORY UPDATE:

DATE	NEW INFORMATION	INITIALS