KINGSWOOD CHIROPRACTIC **ANDREA McCULLOCH, RMT**

Health History Form

Accurate health history ensures that it is safe for you to receive massage treatment, and helps the therapist determine a proper treatment plan. When your health status changes in the future, please let us know. All information gathered on this form is confidential. The information gathered will be released only with your consent or when required by law.

Personal Information

Name:_____ Date: _____

Address: _____ City: _____ Postal Code:_____

Home Tel: _____ Work Tel: _____ Cell:_____

Email: _____ Occupation:_____

Date of Birth: _____ Height:_____ Weight:_____

Doctor:_____ Phone:_____

Emergency Contact Name: _____ Phone:_____

Have you had a massage before? ☐Yes ☐No

Current Medications: Condition it treats:

_____ _____

_____ _____

_____ _____

Major illnesses, injuries, accidents, operations: Date:

_____ _____

_____ _____

_____ _____

Please indicate all conditions you have experienced. Mark *C* for current, *P* for past.

Joint/Soft Tissue Discomfort:
- _ Arms
- _ Upper Back
- _ Mid Back
- _ Lower Back
- _ Feet
- _ Hands
- _ Hips
- _ Jaw
- _ Knees
- _ Legs
- _ Neck
- _ Shoulders
- _ Arthiritis:
  - Type_____
  - Location_____

Other_____

Skin:
- _ Rashes
- _ Itching
- _ Bruise Easily
- _ Dryness
- _ Acne

Other_____

General Symptoms:
- _ Fainting
- _ Dizziness
- _ Loss of Sleep
- _ Fatigue
- _ Nervousness
- _ Sudden Weight Gain/Loss
- _ Numbness
- _ Tingling
- _ Paralysis
- _ Headaches
- _ Migraines

Cardiovascular:
- _ High Blood Pressure
- _ Low Blood Pressure
- _ Coronary Heart Disease
- _ Heart Attach
- _ Phlebitis
- _ Stroke/CVA
- _ Pacemaker
- _ Varicose Veins
- _ Swelling
- _ Poor Circulation

Infectious:
- _ Hepatitis
- _ Tuberculosis
- _ HIV
- _ Herpes
- _ Warts

Other_____

Digestive:
- _ Poor Appetite
- _ Belching/Gas
- _ Constipation
- _ Diarrhea
- _ Nausea
- _ Ulcer
- _ Vomiting
- _ Irritable Bowel

Eye, Ear, Nose Throat:
- _ Allergies
- _ Frequent Colds
- _ Visual Impairment
- _ Hearing Loss
- _ Sinus Infection
- _ Swollen Glands

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Please indicate all conditions you have experienced. Mark *C* for current, *P* for past.

Reproductive (women):
- _ Pregnant / Due date _____
- _ Infertility
- _ Painful Menstruation
- _ Heavy Flow
- _ Irregular Cycle
- _ Painful Breasts
- _ Menopausal
- Other_____

Reproductive (men):
- _ Prostate Issues
- _ Infertility
- Other_____

Respiratory:
- _ Chronic cough
- _ Shortness of breath
- _ Bronchitis
- _ Asthma
- _ Emphysema
- _ Smoker

Other Conditions:
- _ Loss of sensation, where? _____
- _ Diabetes/ type & onset _____
- _ Allergies/hypersensitivity to what?_____ Type of reaction_____
- _ Epilepsy
- _ Cancer, type/where? _____

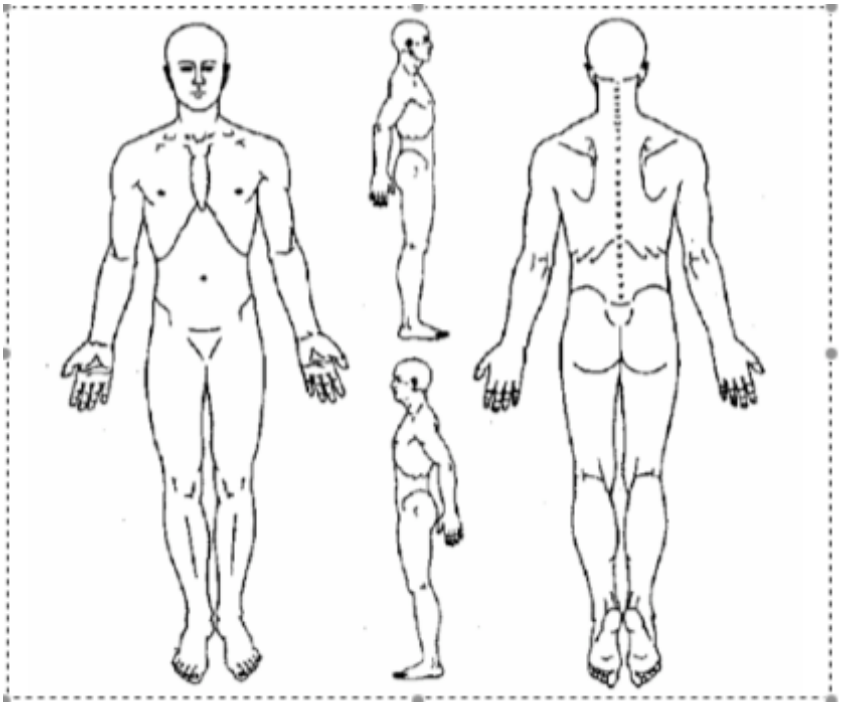
Do you have any other medical conditions? (e.g. haemophilia, osteoporosis, mental illness, multiple sclerosis) ☐Yes ☐No
What?_____

Do you have any internal pins, wires, artificial joints or special equipment?
☐Yes ☐No
What? _____
Where?_____

What is the main reason you are seeking massage therapy?
_____
_____
_____

Please mark the area of injury or discomfort on the chart below, using the appropriate symbols.

Pins & Needles	Burning	Aching	Stabbing
o o o o o o o	^ ^ ^ ^ ^	x x x x x	⊗ ⊗ ⊗ ⊗
o o o o o o o	^ ^ ^ ^ ^	x x x x x	⊗ ⊗ ⊗ ⊗



Please read carefully and sign:
I attest that the information I have provided is true and complete to the best of my knowledge. I understand the information I have provided on this form is confidential and will not be released without my written consent, unless required by law. I understand that 24 hours notice is required to reschedule all future appointments, or full charges will apply.

_____ _____
Signature Date