Erin Mills Optimum Health
3105 Glen Erin Drive # 5
Mississauga, Ontario L5L 1J3
905-828-2014

MASSAGE HEALTH HISTORY FORM

An accurate health history form is important to ensure that it is safe for you to receive treatment. If your health status changes in the future, please let us know. All information 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.

Name: ______________________________ **Sex:** *M* *F*
Address: ______________________________
City: ______________ **Province:** ____________ **Postal Code:** ____________
Telephone: Residence: ______________ **Business:** ______________
Date of Birth: d/_____ **/m**______ **/yr**________ **Weight:** ____________ **Height:** ____________
Occupation: ______________ **Hours per day:** ______________
How did you hear about the clinic?_________________**What is your primary complaint?**___________
General Health Status:_________________

☐ **PLEASE INDICATE CONDITIONS YOU ARE EXPERIENCING, OR HAVE EXPIRIENCED.**

MUSCLES/JOINTS Pain/Stiffness

☐ NECK ☐ ARMS: left/right
☐ UPPER BACK ☐ LEGS: left/right
☐ MID BACK ☐ KNEES: left/right
☐ LOW BACK ☐ HIPS: left/right
☐ SHOULDERS ☐ Other: ______

HEAD/NECK
☐ headaches: type: __________________
☐ vision problems/vision loss

☐ earaches/ear problems
☐ hearing loss

RESPIRATORY
☐ chronic cough ☐ bronchitis
☐ shortness of breath ☐ asthma
☐ smoking ☐ emphysema

COMMUNICABLE DISEASES
☐ TB ☐ HIV (AIDS)
☐ Hepatitis ☐ Other: _________

FEMALE
☐ pregnant: Due Date: _______________
☐ Children: number: _________
☐ Menstrual/menopausal problems

CARDIOVASCULAR

☐ blood pressure: high or low
☐ poor circulation
☐ heart disease
type: _________________
☐ stroke
☐ pacemaker or similar device
☐ hemophilia
☐ varicose veins

OTHER CONDITIONS
☐ sinus
☐ epilepsy
☐ diabetes
☐ allergies
specify:_________________
☐ cancer
specify: _________________
☐ arthritis
specify: _________________
☐ loss of sensation
specify: _________________
☐ skin conditions
specify:_________________

PHYSICIAN: ________________
Phone Number: _______________
Date of Last Visit: _____________
Address: ______________________

CURRENT MEDICATIONS
(List Name and Condition)
____
____
____

SURGERIES
Type:____________________
Date: _________________
Current
Symptoms:______________
____
____

INJURIES/MOTOR VEHICLE ACCIDENTS
Date:
Current Symptoms:________
____
____
____

OTHER HEALTH CARE
☐ Chiropractic
☐ Regular Exercise
☐ Physiotherapy
☐ Previous Massage Therapy
☐ Reflexology
☐ Other:______________

OTHER MEDICAL CONDITIONS: (e.g. digestive conditions, thyroid problems, nervous system, endocrine system, etc.)____
____

OF SPECIAL NOTE: (presence of internal pins, wires, artificial joints, special equipment):
____

CANCELLATION POLICY: A cancellation service charge will apply if less than 24 hours notice has been given.
The clinic will gladly assist you in understanding your insurance, but you agree that you are responsible for your account.

CONSENT TO TREATMENT: ______________________________ **DATE:** _______________