Erin Mills
Optimum Health

Massage Health History Form

3105 Glen Erin Drive, Suite 5
Mississauga, ON L5L 1J3
905.828.2014

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: _____ **Hrs per Day**: _____ **How did you hear of the clinic?** _____
Primary Complaint? _____ **General Health Status**: _____

☐ ***PLEASE INDICATE ANY CONDITIONS YOU ARE EXPERIENCING, OR HAVE EXPERIENCED IN THE PAST.***

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 ☐ Sinus

RESPIRATORY
☐ Emphysema ☐ Chronic Cough
☐ Bronchitis ☐ Shortness of Breath
☐ Asthma ☐ Smoking

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
☐ Epilepsy
☐ Diabetes
☐ Allergies
Specify: _____
☐ Cancer
Specify: _____
☐ Arthritis
Specify/Family History: _____
_____
☐ Loss of Sensation
Specify: _____
☐ Skin Conditions
Specify: _____

PHYSICIAN: _____
Phone Number _____
Date of Last Visit _____
Address _____
Major Intersection _____

CURRENT MEDICATIONS
(List Names & Conditions)
_____
_____
_____

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: (eg. 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 24HOURS 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:** _____