

Confidential Patient Health History Form

Name: _____ Birthdate: _____

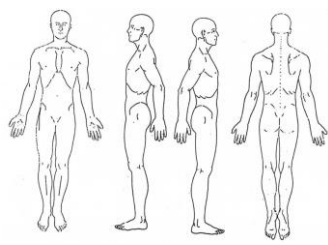
Address: _____ City: _____ Postal Code: _____

Email: _____ Occupation: _____

Cell Phone Number: _____ Work Phone Number: _____

Referred by: _____ Emergency Contact Name and Phone Number: _____

Please indicate conditions you are experiencing or have experienced:

<p>Cardiovascular</p> <ul style="list-style-type: none"> <input type="checkbox"/> High blood pressure <input type="checkbox"/> Low blood pressure <input type="checkbox"/> Chronic congestive heart failure <input type="checkbox"/> Heart attack <input type="checkbox"/> Phlebitis/ varicose veins <input type="checkbox"/> Stroke / CVA <input type="checkbox"/> Pacemaker or similar device <input type="checkbox"/> Heart disease / condition <input type="checkbox"/> Dizziness / Vertigo <input type="checkbox"/> Seizures <p>Any family history to the above? _____</p>	<p>Respiratory</p> <ul style="list-style-type: none"> <input type="checkbox"/> Asthma <input type="checkbox"/> Bronchitis <input type="checkbox"/> Emphysema <input type="checkbox"/> Chronic cough <input type="checkbox"/> Shortness of Breath <input type="checkbox"/> COPD <p>Any family history to the above? _____</p>	<p>Digestive</p> <ul style="list-style-type: none"> <input type="checkbox"/> Constipation <input type="checkbox"/> Crohn's disease <input type="checkbox"/> Colitis <input type="checkbox"/> Irritable Bowel Syndrome <input type="checkbox"/> Ulcers <input type="checkbox"/> Other _____
<p>Head and Neck</p> <ul style="list-style-type: none"> <input type="checkbox"/> History of headaches <input type="checkbox"/> History of migraines <input type="checkbox"/> Vision problems <input type="checkbox"/> Vision loss <input type="checkbox"/> Ear problems <input type="checkbox"/> Hearing loss <input type="checkbox"/> Other _____ 	<p>Muscle / Joint</p> <ul style="list-style-type: none"> <input type="checkbox"/> Circle areas of complaint  <ul style="list-style-type: none"> <input type="checkbox"/> Previous MVC or trauma <input type="checkbox"/> Disc problems <input type="checkbox"/> List previous injuries and surgeries <p>_____</p>	<p>Other</p> <ul style="list-style-type: none"> <input type="checkbox"/> Reaction to applied heat? Cold? _____ <input type="checkbox"/> Loss of sensation Where? _____ <input type="checkbox"/> Diabetes <input type="checkbox"/> Onset _____ Type _____ <input type="checkbox"/> Allergies / sensitivities <input type="checkbox"/> What? _____ <input type="checkbox"/> Epilepsy <input type="checkbox"/> Cancer <input type="checkbox"/> Type _____ <input type="checkbox"/> Location _____ <input type="checkbox"/> Arthritis <input type="checkbox"/> Hemophilia <input type="checkbox"/> Chronic Fatigue <input type="checkbox"/> Fibromyalgia <input type="checkbox"/> Scoliosis <input type="checkbox"/> Polio / Post Polio <input type="checkbox"/> Osteoporosis
<p>Women</p> <ul style="list-style-type: none"> <input type="checkbox"/> Pregnancy <input type="checkbox"/> Due Date: _____ <input type="checkbox"/> Previous pregnancy complications <input type="checkbox"/> Menstrual problems <input type="checkbox"/> Gynecological conditions 	<p>Infections Conditions</p> <ul style="list-style-type: none"> <input type="checkbox"/> Skin conditions _____ <input type="checkbox"/> HIV <input type="checkbox"/> Respiratory conditions <input type="checkbox"/> Hepatitis <p>Skin Conditions</p> <ul style="list-style-type: none"> <input type="checkbox"/> Eczema <input type="checkbox"/> Psoriasis <input type="checkbox"/> Rash <input type="checkbox"/> Warts <input type="checkbox"/> Herpes 	<p>Do you have any artificial joints, pacemakers, internal wires or special equipment that we should be aware of?</p> <p>_____</p> <p>For what condition or reason are you seeking treatment today? _____</p> <p>What are you expecting to achieve with Massage Therapy? _____</p> <p>Please list medication, vitamins, herbs</p> <p>_____</p>

Accurate health information is important to ensure that it is safe for you to receive Massage Therapy. If there are any changes to your health, please inform your Therapist. All information gathered is confidential and is only shared among Therapists to facilitate your treatment and care. Any sharing of your information with third parties requires your written authorization.

I understand that Massage Therapy may include several modalities in addition to manual therapy.

Massage Therapy at South West Massage may include: Cupping Therapy Hot/Cold Stones GuaSha Energy work Lymphatic Drainage Reflexology
By signing below, I consent to receiving these additional modalities and understand that I may discuss, change/modify/withdraw my consent, at any time by informing my therapist.

I understand and will adhere to the 24hour cancellation policy to avoid charges being applied to my account.

Signature: _____ Date: _____