

LiveWell

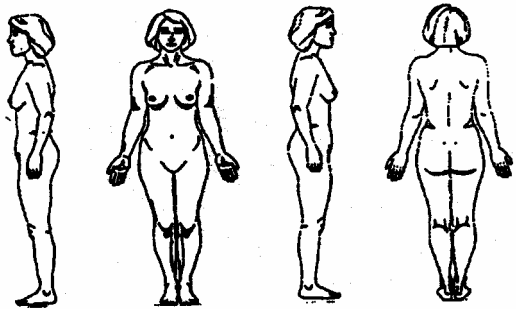
Family Health Centre
 Chiropractic • Massage • Yoga • Nutrition
 Natural Pharmacy • Orthotics • Naturopathy

HEALTH HISTORY

Name: _____ Today's Date (D/M/Y): _____
 Name you preferred to be called: _____ Date of Birth (D/M/Y): _____ Age _____
 Address: _____ City: _____ Postal Code: _____
 Phone: Home _____ Work: _____ Occupation: _____
 E-mail: _____ May we contact you by email: Yes No
 Marital Status: Single Married Widowed Divorced Other Children: No Yes #__
 Physician Name: _____ Phone Number: _____
 Who referred you? /How did you hear about us?: _____

1) Have you seen a massage therapist before? Yes No
 If yes, Therapist's name: _____ Last Visit: _____

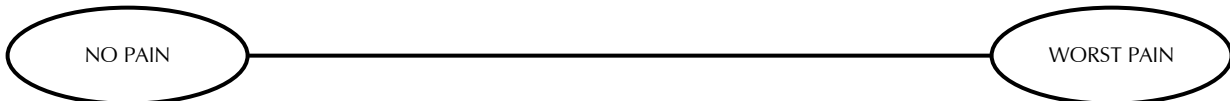
2) What brings you in for massage? Wellness _____ Physical Complaint_
 If it is a physical complaint please shade in the areas below:



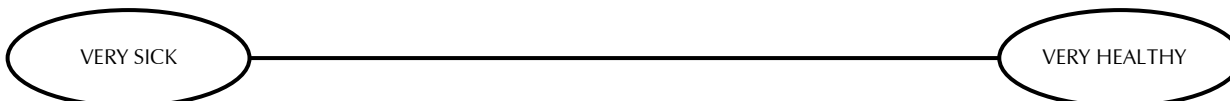
What symptoms are you experiencing?

- | | |
|------------------------------------|------------------------------------|
| <input type="checkbox"/> Dull ache | <input type="checkbox"/> Tingling |
| <input type="checkbox"/> Twitching | <input type="checkbox"/> Cramping |
| <input type="checkbox"/> Fiery | <input type="checkbox"/> Stabbing |
| <input type="checkbox"/> Sharp | <input type="checkbox"/> Stiffness |
| <input type="checkbox"/> Radiating | <input type="checkbox"/> Swelling |
| <input type="checkbox"/> Weakness | <input type="checkbox"/> Numbness |

3) How would you rate the severity of your complaint? Please mark a vertical line on the scale below.



4) How would you rate your overall health? Please mark a vertical line on the scale below.



5) Are you pregnant? Yes No If yes, Due Date: _____

6) Are you allergic to any oils? Yes No
 If yes, please list: _____

7) Are you currently taking any medications? Yes No
 If yes, please list: _____

8) Please finish the following sentences by circling a number from 1 to 10.

(1 – poor, 5 – average, 10 – excellent)

My STRESS LEVEL is:	1	2	3	4	5	6	7	8	9	10
My ENERGY LEVEL is:	1	2	3	4	5	6	7	8	9	10
My BREATHING is:	1	2	3	4	5	6	7	8	9	10
My LEVEL OF RELAXATION is:	1	2	3	4	5	6	7	8	9	10
My QUALITY OF SLEEP is:	1	2	3	4	5	6	7	8	9	10
My DIGESTION is:	1	2	3	4	5	6	7	8	9	10
My MEMORY is:	1	2	3	4	5	6	7	8	9	10
My RESISTANCE TO ILLNESS is:	1	2	3	4	5	6	7	8	9	10
My FLEXIBILITY is:	1	2	3	4	5	6	7	8	9	10
My CONCENTRATION is:	1	2	3	4	5	6	7	8	9	10
My Comfort during menstruation is:	1	2	3	4	5	6	7	8	9	10
My Regularity of menstruation is:	1	2	3	4	5	6	7	8	9	10

9) List any operations, motor vehicle accidents and/or hospitalizations and the year they occurred: _____

10) Please check the conditions you are experiencing now or have in the past:

General

- Headache
- Fatigue
- Dizziness
- Anxiety
- Rash
- Allergies

Respiratory

- Asthma
- Bronchitis
- Chronic cough
- Emphysema
- Short breath
- Sinusitis

Cardiovascular

- High blood pressure
- Low blood pressure
- Heart disease
- Heart attack
- Stroke/ TIA
- Varicose Veins/Phlebitis

Digestion

- Ulcer
- Constipation
- Diarrhea
- Hiatus hernia
- Crohns/Colitis
- IBS

Other Conditions

- Arthritis
- Bruising
- Hepatitis/TB
- Cancer
- Hemophilia
- HIV
- Diabetes
- Pacemaker
- Epilepsy/Convulsions
- Depression
- Internal pins/wires
- Artificial joints

Use this space to elaborate on any of the above conditions or any conditions that have not been listed:

11) Please list a brief family health history: _____

12) What health goals would you like to achieve through massage therapy: _____

Conditions and Cancellation Policy

Cancellations or changes less than 24 hours prior to the appointment time are subject to full fee.

Name: _____ Signature: _____ Date: _____