

# LiveWell

## Family Health Centre

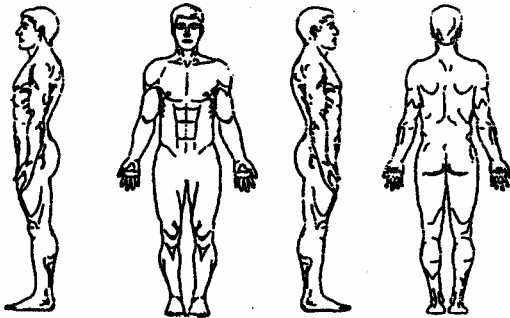
Chiropractic • Massage • Yoga • Nutrition  
Natural Pharmacy • Orthotics • Naturopathy

**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:

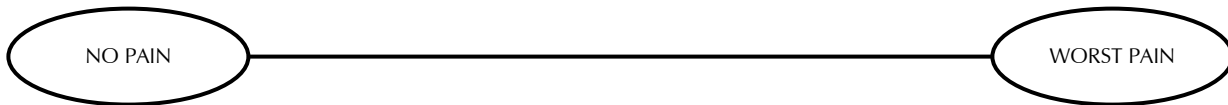


What symptoms are you experiencing?

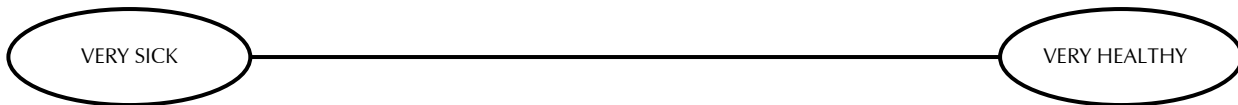
- |                                    |                                    |
|------------------------------------|------------------------------------|
| <input type="checkbox"/> Dull ache | <input type="checkbox"/> Tingling  |
| <input type="checkbox"/> Twitching | <input type="checkbox"/> Cramping  |
| <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 allergic to any oils? Yes No

If yes, please list: \_\_\_\_\_

6) Are you currently taking any medications? Yes No

If yes, please list: \_\_\_\_\_

7) 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

8) List any operations, motor vehicle accidents and/or hospitalizations and the year they occurred: \_\_\_\_\_

9) 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:

10) Please list a brief family health history: \_\_\_\_\_

11) 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: \_\_\_\_\_