LiveWell
Family Health Centre
Chiropractic • Massage • Fitness Training • 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:_____

Marital Status: Single Married Widowed Divorced Other Children: No Yes #_____

Physician Name:_____ Phone Number: _____

Who referred you? /How did you hear about us?_____

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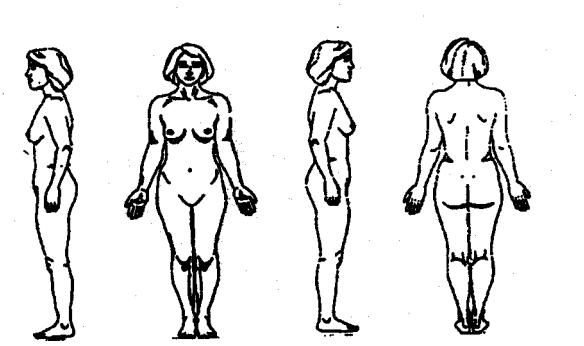
1) Have you seen a massage therapist before? Yes No Last Visit:_____

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?

- ❑ Dull ache
- ❑ Twitching
- ❑ Fiery
- ❑ Sharp
- ❑ Radiating
- ❑ Weakness
- ❑ Tingling
- ❑ Cramping
- ❑ Stabbing
- ❑ Stiffness
- ❑ Swelling
- ❑ Numbness

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

NO PAIN ——— WORST PAIN

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

VERY SICK ——— VERY HEALTHY

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

6) Gynaecological conditions? Please list_____

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

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

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: ("P" if in the past)

General
- ❑ Headache
- ❑ Fatigue
- ❑ Dizziness
- ❑ Anxiety
- ❑ Allergies
- ❑ Skin Conditions
- ❑ Rash

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

Cardiovascular
- ❑ High blood pressure
- ❑ Low blood pressure
- ❑ Heart disease
- ❑ Heart attack
- ❑ Stroke/ TIA/CVA
- ❑ Chronic congestive heart failure
- ❑ Varicose Veins/Phlebitis

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

Other Conditions
- ❑ Arthritis
- ❑ Bruising
- ❑ Hepatitis/TB
- ❑ Vision Loss
- ❑ Cancer
- ❑ Hemophilia
- ❑ HIV
- ❑ Hearing Loss
- ❑ Diabetes
- ❑ Pacemaker
- ❑ Epilepsy/Convulsions
- ❑ Loss of sensation
- ❑ Depression
- ❑ Internal pins/wires
- ❑ Artificial joints

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

11) Do you have a family history of any of these conditions?_____
_____

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

13) Are you currently receiving treatment from another health care professional? If so, what for? _____
_____

At LiveWell Family Health Centre, we use e-mail and other firms of electronic communication to conduct regular business with our clients. We never share this information with any individual or third party outside our Centre. Please initial the following statement:
I give permission to LiveWell Family Health Centre to send me statements, receipts, appointment reminders/calendars, upcoming events notices, newsletters and/or other health information via e-mail.

Please Initial ☐

Conditions and Cancellation Policy

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

Name: _____ **Signature:** _____ **Date:** _____