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 #____

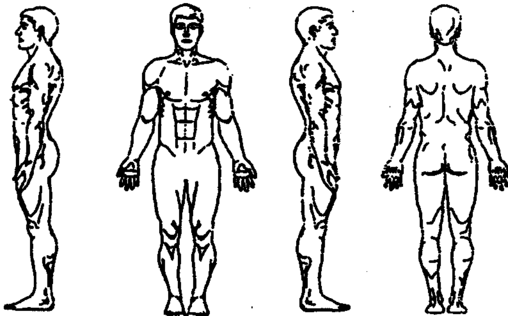
Physician Name:____________________ Phone Number: ____________________

Who referred you? /How did you hear about us?:________________________________

---

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?

- ❑ 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 allergic to any oils? Yes No

If yes, please list: ______________________________

6) Are you currently taking any medications? Yes No

If yes, please list: ______________________________

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	Respiratory	Cardiovascular	Digestion
❑ Headache	❑ Asthma	❑ High blood pressure	❑ Ulcer
❑ Fatigue	❑ Bronchitis	❑ Low blood pressure	❑ Constipation
❑ Dizziness	❑ Chronic cough	❑ Heart disease	❑ Diarrhea
❑ Anxiety	❑ Emphysema	❑ Heart attack	❑ Hiatus hernia
❑ Rash	❑ Short breath	❑ Stroke/ TIA	❑ Crohns/Colitis
❑ Allergies	❑ Sinusitis	❑ Varicose Veins/Phlebitis	❑ IBS

Other Conditions

❑ Arthritis	❑ Cancer	❑ Diabetes	❑ Depression
❑ Bruising	❑ Hemophilia	❑ Pacemaker	❑ Internal pins/wires
❑ Hepatitis/TB	❑ HIV	❑ Epilepsy/Convulsions	❑ 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: ______________________________

____

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: __________