Stillpoint Massage Therapy

Therapist Initials:

Health History Form

This information is to help the therapist create a safe and effective treatment plan.

Name: _____ Today's Date: _____

Address: _____ Date of Birth: _____

City: _____ Postal Code: _____ Occupation: _____

Phone: ( ) _____ Cell: ( ) _____ Work Phone: ( ) _____

Email Address *(optional)*: _____ Physician: _____

How did you hear about Stillpoint Massage Therapy? _____ Physician Phone: ( ) _____

What is your chief complaint? _____ Care Card Number: _____

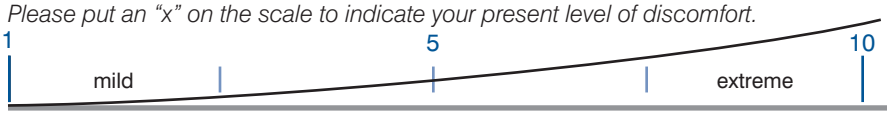
☐ ICBC or ☐ WCB Claim #: _____

Extended Medical: yes ☐ no ☐

Insurer: _____

PAIN SCALE –

Please put an "x" on the scale to indicate your present level of discomfort.



Please check ☑ conditions you are experiencing and (circle) conditions you have experienced in the past.

SKIN
- ☐ Eczema
- ☐ Psoriasis
- ☐ Rashes / bruise easily
- ☐ Other skin conditions: _____

MUSCLES / JOINTS

Indicate left (L) or right (R) where appropriate
- ☐ Neck
- ☐ Upper back
- ☐ Mid back
- ☐ Lower back
- ☐ Shoulder
- ☐ Elbows
- ☐ Arm
- ☐ Wrist
- ☐ Hand
- ☐ Hip
- ☐ Leg
- ☐ Knee
- ☐ Ankle
- ☐ Foot
- ☐ Weakness or loss of strength
- ☐ Clumsiness
- ☐ Osteoarthritis
- ☐ Rheumatoid arthritis
- ☐ Osteoporosis
- ☐ Tendinitis: Location: _____ Date: _____
- ☐ Joint sprain / dislocation: Location: _____ Date: _____
- ☐ Other injury: _____

PREGNANCY

Trimester: 1st ☐ 2nd ☐ 3rd ☐

RESPIRATORY
- ☐ Asthma
- ☐ Chronic cough
- ☐ Emphysema
- ☐ Smoking
- ☐ Bronchitis
- ☐ Difficult breathing
- ☐ Shortness of breath
- ☐ Chronic Sinusitis
- ☐ Other: _____

CARDIOVASCULAR
- ☐ Bleeding disorder
- ☐ High / low blood pressure: _____
- ☐ Heart attack
- ☐ Angina
- ☐ Varicose Veins
- ☐ Poor circulation
- ☐ Heart disease
- ☐ Pacemaker
- ☐ Phlebitis
- ☐ Aneurysm
- ☐ Stroke / cerebrovascular accident
- ☐ Other: _____

HEAD / NECK
- ☐ Visual impairment: _____
- ☐ Hearing impairment: _____
- ☐ Speech impairment: _____
- ☐ Head injury _____
- ☐ Spinal injury: _____
- ☐ Headache / migraine
- ☐ Jaw pain *(temporomandibular joint {TMJ} pain)*

GASTROINTESTINAL
- ☐ Constipation
- ☐ Irritable bowel
- ☐ Hernia
- ☐ Diarrhea
- ☐ Colitis
- ☐ Ulcers
- ☐ Other: _____

OTHER CONDITIONS
- ☐ Fibromyalgia
- ☐ Chronic pain *please describe* _____
- ☐ Kidney disease
- ☐ Diabetes
- ☐ Seizures
- ☐ Insomnia
- ☐ Fainting
- ☐ Cancer
- ☐ Fever
- ☐ Epilepsy
- ☐ Stress
- ☐ Nausea
- ☐ Numbness / tingling: *where?* _____
- ☐ Allergies (medications, foods, seasonal, oils, lotions, etc.) _____

INFECTIOUS CONDITIONS
- ☐ Hepatitis
- ☐ HIV
- ☐ TB
- ☐ Other: _____

FRACTURE:

Location: _____

Date: _____

SURGERY:

Location: _____

Date: _____
- ☐ Rods / pins / plates / shunts
- ☐ Implants
- ☐ Transplants

MOTOR VEHICLE ACCIDENT: no ☐ yes ☐

Symptoms: _____

Date: _____

MEDICATIONS currently taking: *Why?*

FAMILY HISTORY OF MEDICAL CONDITIONS:

If yes, please list: _____

OTHER HEALTH CARE received:

I understand that my personal and medical information is confidential and will only be disclosed to third parties with my permission.

I also understand that my appointment time has been reserved for me and if I need to cancel or reschedule, 24 hours notice is required, or a cancellation fee may apply.

Signature: _____ Date: _____