Happy Family Wellness Clinic
10815 Bathurst St., Richmond Hill, ON L4C 9Y2
Tel.: 905-737-5559, Fax: 905-737-5556
www.HappyFamilyWellness.ca

Confidential Health History Form

An accurate health history is important to ensure that it is safe for you to receive a massage treatment. All information gathered for this treatment is confidential except as required or allowed by law. Written authorization will be required for release of any information.
24 hour cancellation notice is required or a missed appointment fee will be charged.

Name:______________________________ Email: ______________________

Home:(________)____________________ Work:(________)____________________ Cell:(________)____________________

Address:______________________________ City:____________________ Postal Code:______________

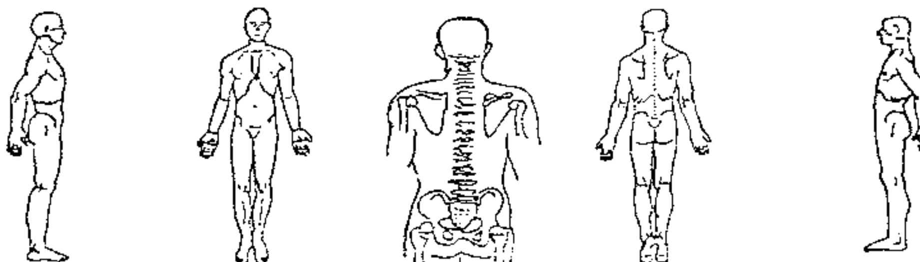
Date of birth:_____/_____/_____ (D M Y) Occupation:______________________ First time for Massage Therapy: YES / NO

Family Physician: ______________________ Address:______________________________

Who can we thank for referring you here?____________________ If Doctor – Address:____________________

Reason for Massage Therapy Treatment: ______________________________

Indicate pain and/or stiffness by shading in the area – Indicate numbness and/or tingling with an 'N' or 'T'



Health History: Please check spaces below for any conditions that you are experiencing or have experienced

Soft Tissue/Joints
- ❑ tendonitis / bursitis
- ❑ weakness ____________
- ❑ sprains / strains
- ❑ arthritis – OA / RA / other

location: ____________________
- ❑ herniated discs

Headaches
- ❑ tension headaches
- ❑ migraines
- ❑ tooth / jaw/ ear pain (circle)
- ❑ head trauma – date: __________

Accident / Injury
- ❑ car accident
- ❑ whiplash

date: ____________________
symptoms: ____________________
physical limitations:
____
- ❑ fractures

Women
- ❑ pregnant – due date:____________
- ❑ gynaecological conditions

Surgery
Type:____________________
Date:____________________
Current symptoms____________________

Respiratory
- ❑ chronic cough
- ❑ shortness of breath
- ❑ bronchitis
- ❑ asthma
- ❑ emphysema
- ❑ pneumonia
- ❑ sinus problems

Cardiovascular
- ❑ high blood pressure
- ❑ low blood pressure
- ❑ heart attack
- ❑ phlebitis
- ❑ stroke / CVA
- ❑ pacemaker
- ❑ heart disease
- ❑ angina
- ❑ chronic congestive heart failure

Infectious Disease
- ❑ hepatitis
- ❑ tuberculosis
- ❑ HIV/AIDS
- ❑ other: ____________________

Current Medications & Conditions
____
____
____

Skin
- ❑ skin condition:
- ❑ bruise easily
- ❑ herpes
- ❑ varicose veins
- ❑ athletes foot
- ❑ warts / plantar warts
- ❑ loss of sensation

Other Conditions
- ❑ neurological conditions
- ❑ epilepsy
- ❑ diabetes-onset:______________
- ❑ allergies - **anaphylaxis Y / N**
- ❑ cancer ____________________
- ❑ vision problems
- ❑ hearing loss or tinitis
- ❑ constipation
- ❑ other digestive conditions:

____
- ❑ insomnia / poor sleeping patterns
- ❑ kidney / bladder problems
- ❑ haemophilia
- ❑ fibromyalgia
- ❑ osteoporosis
- ❑ surgical implants (pins, plates, etc)

Present Involvement in Other Healthcare: YES / NO
If Yes Specify: ____________________
____

General Health Status: excellent / good / fair / poor **Family History of Arthritis?** Yes / No

I have read the above information and have stated all my previous medical conditions. I take it upon myself to update the massage therapist regarding any changes in my condition. I understand that all massage treatments will be discussed and planned with the massage therapist, and will required my informed consent.

Signature: ______________________________ **Date:** ____________________