Jeremy Bissonnette *Registered Massage Therapist*

HEALTH HISTORY FORM

For your information:

An accurate health history is important to ensure that it is safe for you to receive a massage treatment. If your health status changes in the future, please let me know. All information gathered for this treatment is confidential except as required or allowed by law or except to facilitate diagnosis (assessment) or treatment. You will be asked to provide written authorization for release of any information.

Name: _____Date: _____

Tel: res _____

Address: _____ bus _____

_____ Fax/email _____

Date of birth: _____Occupation: _____What is your primary complaint? _____

Who referred you? _____Their address? _____

Health History: ! Please indicate conditions you are experiencing, or have experienced:

Respiratory

- ☐ chronic cough
- ☐ shortness of breath
- ☐ bronchitis
- ☐ asthma
- ☐ emphysema

Cardiovascular

- ☐ high blood pressure
- ☐ low blood pressure
- ☐ CCHF
- ☐ heart attack
- ☐ phlebitis
- ☐ stroke/CVA
- ☐ pacemaker or
- ☐ similar device
- ☐ heart disease

Skin

- ☐ skin conditions

Other Conditions

- ☐ loss of sensation
- ☐ diabetes (onset: _____)
- ☐ allergies(ie.anaphylaxis or skin irritation)
- ☐ epilepsy
- ☐ cancer
- ☐ arthritis

Head/Neck

- ☐ vision problems
- ☐ vision loss
- ☐ ear problems
- ☐ hearing loss

Infections

- ☐ hepatitis
- ☐ skin conditions
- ☐ TB
- ☐ HIV

Women

- ☐ pregnant (due:_____)

Soft tissue/joint discomfort and its nature

- ☐ neck _____
- ☐ low back _____
- ☐ mid back _____
- ☐ upper back _____
- ☐ shoulders _____
- ☐ arms _____
- ☐ legs _____
- ☐ knees _____
- ☐ other _____

What is your general health status?

_____

Current Medications: _____

Condition it treats: _____

Surgery: _____ date: _____

nature: _____

Injury: _____ date: _____

nature: _____

Primary Care Physician: _____

Address: _____

Present Involvement in Other Health care:

☐ Yes ☐ No

If yes, please specify: _____

_____

_____

Other Medical Conditions (e.g. digestive conditions, gynaecological conditions, hemophilia, etc.):_____

_____

Of Special Note:(presence of internal pins, wires, artificial joints, special equipment): _____

_____