St. Andrew's Chiropractic & Wellness

MASSAGE THERAPY PATIENT HEALTH HISTORY FORM

14845 Yonge St. Unit 4 ▪ Aurora, ON ▪ L4G 6H8

905-727-6500 ▪ www.standrewschiro.ca

Name: _____ Date of Birth: _____Sex: M / F

Address: _____ Apt. #_____

City: _____ Postal Code: _____

Home Phone: _____ Work/Cell/Other Phone_____

E-mail:_____

Occupation: _____ Employed by: _____

Family Doctor Name, Address and Phone Number: _____

_____

Emergency Contact Name: _____Phone:_____

How were you referred to our clinic? _____

Have you received massage therapy before? Y/N

Are you currently receiving treatment from another health care practitioner? _____

What is your primary complaint? _____

When did your symptoms begin? _____

Rate your pain level: (low) 0 - - - - 5 - - - - 10 (high)

Is this condition interfering with (circle all that applies):

WORK SLEEP DAILY ROUTINE ACTIVITIES

Please list any current medications:

_____

Please list any surgery/injuries/hospitalization (date, past & current):

_____

Do you have any internal pins/wires/artificial joints? _____

What is your current overall health status? _____

Are your injuries as a result of: Motor Vehicle Accident Yes/No or Workplace injury (WSIB) Yes/No

Have you (or family member) experienced any of the following conditions? If so, please indicate which ones:

Family History	Self	
		Cardiovascular
☐	☐	High blood pressure
☐	☐	Low blood pressure
☐	☐	Chronic congestive heart failure
☐	☐	Heart attack
☐	☐	Phlebitis/varicose veins
☐	☐	Stroke/CVA
☐	☐	Pacemaker or similar device
☐	☐	Heart disease
		Respiratory
☐	☐	Chronic cough
☐	☐	Shortness of breath
☐	☐	Bronchitis
☐	☐	Asthma
☐	☐	Emphysema
☐	☐	Smoker?
		Head and Neck
☐	☐	History of headaches
☐	☐	History of migraines
☐	☐	Vision problems
☐	☐	Vision loss
☐	☐	Ear problems
☐	☐	Hearing loss

Family History	Self	
		Soft Tissue/Joint Pain
☐	☐	Neck
☐	☐	Upper back/shoulders
☐	☐	Arms/hands
☐	☐	Mid back
☐	☐	Low back
☐	☐	Hips
☐	☐	Legs
☐	☐	Knees
☐	☐	Feet
☐	☐	Other _____
		Infections
☐	☐	Hepatitis
☐	☐	Skin conditions/rash
☐	☐	TB
☐	☐	HIV
☐	☐	Herpes
		Women
☐	☐	Pregnant. Due:
☐	☐	Gynaecological issues. What:_____ _____

Family History	Self	
		Other
☐	☐	Loss of sensation. Where:_____
☐	☐	Diabetes. Onset: _____
☐	☐	Allergies. To what:_____
☐	☐	Epilepsy
☐	☐	Cancer. Where:_____
☐	☐	Fibromyalgia
☐	☐	Swelling in the ankles
☐	☐	Bruise easily
☐	☐	Arthritis
☐	☐	Digestive conditions
☐	☐	Hemophilia
☐	☐	Osteoporosis
☐	☐	Mental illness
☐	☐	Dizziness/Fainting
☐	☐	Other:_____ _____
		Gastrointestinal
☐	☐	Diarrhea
☐	☐	Indegstion/heartburn
☐	☐	Constipation
☐	☐	Other:_____

WHAT ARE YOUR GOALS FOR MASSAGE THERAPY? _____

_____