

Kawartha Therapeutic Centre

Janis Jenkinson, Registered Massage Therapist

265 Kent St. West, Lindsay, ON, K9V 2Z3

Tel: (705) 878-0463

Date of initial health history: _____

Health History Form

The information request below will assist us in treating you safely. Feel free to ask any questions about the information being requested. Please note that all information provided below will be kept confidentially unless allowed or required by law. Your written permission will be required to release any information.

Name: _____ Phone #: _____

Address: _____ City: _____ Postal Code: _____

Occupation: _____ Date of Birth: _____

Have you received massage therapy before? Yes No

Did a health care practitioner refer you for massage therapy? Yes No

If yes, please provide their name and address. _____

If no, who referred you? _____ Email: _____

Please indicate conditions you are experiencing or have experienced:

<p>Cardiovascular</p> <ul style="list-style-type: none"><input type="checkbox"/> high blood pressure<input type="checkbox"/> low blood pressure<input type="checkbox"/> chronic congestive heart failure<input type="checkbox"/> heart attack<input type="checkbox"/> phlebitis / varicose veins<input type="checkbox"/> stroke / CVA<input type="checkbox"/> pacemaker or similar device<input type="checkbox"/> heart disease <p><i>Is there a family history of any of the above?</i> <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Respiratory</p> <ul style="list-style-type: none"><input type="checkbox"/> chronic cough<input type="checkbox"/> shortness of breath<input type="checkbox"/> bronchitis<input type="checkbox"/> asthma<input type="checkbox"/> emphysema <p><i>Is there a family history of any of the above?</i> <input type="checkbox"/> Yes <input type="checkbox"/> No</p>	<p>Infections</p> <ul style="list-style-type: none"><input type="checkbox"/> hepatitis<input type="checkbox"/> skin conditions<input type="checkbox"/> TB<input type="checkbox"/> HIV<input type="checkbox"/> herpes <p>Other Conditions</p> <ul style="list-style-type: none"><input type="checkbox"/> loss of sensation, where? _____<input type="checkbox"/> diabetes, onset: _____<input type="checkbox"/> allergies/hypersensitivity to what? _____<input type="checkbox"/> type of reaction: _____<input type="checkbox"/> epilepsy<input type="checkbox"/> cancer, what? _____<input type="checkbox"/> skin conditions, what? _____<input type="checkbox"/> arthritis <p><i>Is there a family history of arthritis?</i> <input type="checkbox"/> Yes <input type="checkbox"/> No</p>	<p>Head / Neck</p> <ul style="list-style-type: none"><input type="checkbox"/> history of headaches<input type="checkbox"/> history of migraines<input type="checkbox"/> vision problems<input type="checkbox"/> vision loss<input type="checkbox"/> ear problems<input type="checkbox"/> hearing loss <p>Women</p> <ul style="list-style-type: none"><input type="checkbox"/> pregnant, due: _____<input type="checkbox"/> gynaecological conditions, what? _____ <hr/> <p>Overall, how is your general health?</p> <hr/> <p>Primary Care Physician:</p> <p>Address: _____</p> <hr/> <hr/>
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Current Medications & Condition it treats:

1) _____ treats _____

2) _____ treats _____

3) _____ treats _____

Are you currently receiving treatment from another health care professional? Yes No

If yes, for what? _____

Surgery _____ Date _____

Injury _____ Date _____

Do you have any other medical conditions? (e.g. digestive conditions, haemophilia, osteoporosis, mental illness) Yes No

What? _____

Do you have any internal pins, wires, artificial joints or special equipment? Yes No

What & where? _____

What is the reason you are seeking massage therapy? Please include the location of any tissue or joint discomfort. _____