

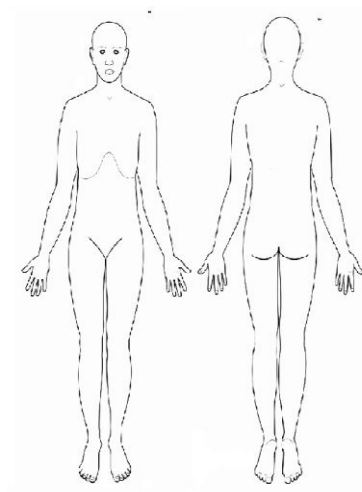
Health History
Grand River Massage Therapy Clinic

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 inform your therapist. All information gathered for this treatment is confidential except as required or allowed by law or except to facilitate assessment or treatment. You will be asked to provide written authorization for releases of any information.

Name: _____ Today's Date: _____
Address: _____ Date Of Birth: _____
City: _____ P.C.: _____ Telephone #: _____
Occupation: _____ Who referred you?: _____
Email Address: _____ Cell Phone #: _____
Primary Care Physician: _____ General Health Status: Poor Fair Good
Other Health Care: Chiropractor Naturopath Physiotherapist
Emergency Contact: _____ Telephone#: _____
Primary Complaint: _____
How long have you had this condition? _____
What aggravates this condition? _____
What relieves this condition? _____
Current medications and conditions treated: _____

Surgical operations? Date? _____
Presence of pins, wires, artificial joints, plates? _____
Major accidents? Date? _____

Please indicate the areas you wish to have treated.



Please indicate all current and past conditions you have experienced.

Head/Neck	Current	Past	Respiratory/Lungs	Current	Past	Digestive	Current	Past
Whiplash	<input type="checkbox"/>	<input type="checkbox"/>	Asthma	<input type="checkbox"/>	<input type="checkbox"/>	Constipation	<input type="checkbox"/>	<input type="checkbox"/>
Headache	<input type="checkbox"/>	<input type="checkbox"/>	Bronchitis	<input type="checkbox"/>	<input type="checkbox"/>	Diarrhea	<input type="checkbox"/>	<input type="checkbox"/>
Migraine	<input type="checkbox"/>	<input type="checkbox"/>	Emphysema	<input type="checkbox"/>	<input type="checkbox"/>	Crohn's	<input type="checkbox"/>	<input type="checkbox"/>
Concussion	<input type="checkbox"/>	<input type="checkbox"/>	Pneumonia	<input type="checkbox"/>	<input type="checkbox"/>	I.B.S	<input type="checkbox"/>	<input type="checkbox"/>
Ring in ears	<input type="checkbox"/>	<input type="checkbox"/>	Short of breath	<input type="checkbox"/>	<input type="checkbox"/>	Ulcers	<input type="checkbox"/>	<input type="checkbox"/>
Hearing Loss	<input type="checkbox"/>	<input type="checkbox"/>	Sinusitis	<input type="checkbox"/>	<input type="checkbox"/>	Diverticulitis	<input type="checkbox"/>	<input type="checkbox"/>
Vision Problems	<input type="checkbox"/>	<input type="checkbox"/>	Frequent Colds	<input type="checkbox"/>	<input type="checkbox"/>	Nausea	<input type="checkbox"/>	<input type="checkbox"/>
Brain Injury	<input type="checkbox"/>	<input type="checkbox"/>	Recurrent lung infection	<input type="checkbox"/>	<input type="checkbox"/>			
TMJ (Jaw Pain)	<input type="checkbox"/>	<input type="checkbox"/>	Chronic Cough	<input type="checkbox"/>	<input type="checkbox"/>			
Other:_____	<input type="checkbox"/>	<input type="checkbox"/>	Other:_____	<input type="checkbox"/>	<input type="checkbox"/>	Other:_____	<input type="checkbox"/>	<input type="checkbox"/>

Cardiovascular	Current	Past	Nervous System	Current	Past	Infections	Current	Past
High B.P. ___/___	<input type="checkbox"/>	<input type="checkbox"/>	Spinal Cord Injury	<input type="checkbox"/>	<input type="checkbox"/>	Hepatitis	<input type="checkbox"/>	<input type="checkbox"/>
Low B.P. ___/___	<input type="checkbox"/>	<input type="checkbox"/>	Numbness/Tingling	<input type="checkbox"/>	<input type="checkbox"/>	Type_____		
Heart Attack	<input type="checkbox"/>	<input type="checkbox"/>	Sensory Change/Loss	<input type="checkbox"/>	<input type="checkbox"/>	Skin	<input type="checkbox"/>	<input type="checkbox"/>
C.C.H.F	<input type="checkbox"/>	<input type="checkbox"/>	Sciatica	<input type="checkbox"/>	<input type="checkbox"/>	Conditions		
Chest pain/angina	<input type="checkbox"/>	<input type="checkbox"/>	Thoracic Outlet (TOS)	<input type="checkbox"/>	<input type="checkbox"/>	TB	<input type="checkbox"/>	<input type="checkbox"/>
Stroke	<input type="checkbox"/>	<input type="checkbox"/>	Seizures	<input type="checkbox"/>	<input type="checkbox"/>	HIV	<input type="checkbox"/>	<input type="checkbox"/>
Pace Maker	<input type="checkbox"/>	<input type="checkbox"/>	Multiple Sclerosis	<input type="checkbox"/>	<input type="checkbox"/>			
Phlebitis	<input type="checkbox"/>	<input type="checkbox"/>	Cerebral Palsy	<input type="checkbox"/>	<input type="checkbox"/>			
Hemophilia	<input type="checkbox"/>	<input type="checkbox"/>	Epilepsy	<input type="checkbox"/>	<input type="checkbox"/>			
Heart Disease	<input type="checkbox"/>	<input type="checkbox"/>	Carpal Tunnel	<input type="checkbox"/>	<input type="checkbox"/>			
Blood Clot	<input type="checkbox"/>	<input type="checkbox"/>	Muscular Dystrophy	<input type="checkbox"/>	<input type="checkbox"/>			
Other:_____	<input type="checkbox"/>	<input type="checkbox"/>	Other:_____	<input type="checkbox"/>	<input type="checkbox"/>	Other:_____	<input type="checkbox"/>	<input type="checkbox"/>

Disease/Condition	Current	Past	Skin Conditions	Current	Past	Bone/Joint	Current	Past
Cancer	<input type="checkbox"/>	<input type="checkbox"/>	Eczema	<input type="checkbox"/>	<input type="checkbox"/>	Dislocation	<input type="checkbox"/>	<input type="checkbox"/>
Type/Location_____	_____	_____	Dermatitis	<input type="checkbox"/>	<input type="checkbox"/>	Fracture	<input type="checkbox"/>	<input type="checkbox"/>
Treatment_____	_____	_____	Acne	<input type="checkbox"/>	<input type="checkbox"/>	Arthritis	<input type="checkbox"/>	<input type="checkbox"/>
Fibromyalgia	<input type="checkbox"/>	<input type="checkbox"/>	Frost Bite	<input type="checkbox"/>	<input type="checkbox"/>	DDD	<input type="checkbox"/>	<input type="checkbox"/>
Chronic Fatigue	<input type="checkbox"/>	<input type="checkbox"/>	Psoriasis	<input type="checkbox"/>	<input type="checkbox"/>	Herniated Disc	<input type="checkbox"/>	<input type="checkbox"/>
Allergies	<input type="checkbox"/>	<input type="checkbox"/>	Sensitive Skin	<input type="checkbox"/>	<input type="checkbox"/>			
Diabetes (Type___)	<input type="checkbox"/>	<input type="checkbox"/>	Rash/Eruptions	<input type="checkbox"/>	<input type="checkbox"/>	Family History	Yes	No
Onset:_____	_____	_____	Cold Sores	<input type="checkbox"/>	<input type="checkbox"/>	Of Arthritis?	<input type="checkbox"/>	<input type="checkbox"/>
			Herpes	<input type="checkbox"/>	<input type="checkbox"/>			
Other:_____	<input type="checkbox"/>	<input type="checkbox"/>	Other:_____	<input type="checkbox"/>	<input type="checkbox"/>	Other:_____	<input type="checkbox"/>	<input type="checkbox"/>

Soft Tissue/Joint	Current	Past	Soft Tissue/Joint	Current	Past	Women Only	Current	Past
Neck	<input type="checkbox"/>	<input type="checkbox"/>	Feet	<input type="checkbox"/>	<input type="checkbox"/>	Pregnancy	<input type="checkbox"/>	<input type="checkbox"/>
Shoulder	<input type="checkbox"/>	<input type="checkbox"/>	Tendonitis	<input type="checkbox"/>	<input type="checkbox"/>	Vaginal Birth	<input type="checkbox"/>	<input type="checkbox"/>
Arm	<input type="checkbox"/>	<input type="checkbox"/>	Swelling	<input type="checkbox"/>	<input type="checkbox"/>	# of weeks____		
Wrist/Hand	<input type="checkbox"/>	<input type="checkbox"/>	Strain/Sprain	<input type="checkbox"/>	<input type="checkbox"/>	# of kids_____		
Back	<input type="checkbox"/>	<input type="checkbox"/>	Restricted Movement	<input type="checkbox"/>	<input type="checkbox"/>			
Hips	<input type="checkbox"/>	<input type="checkbox"/>	Poor Posture	<input type="checkbox"/>	<input type="checkbox"/>			
Legs	<input type="checkbox"/>	<input type="checkbox"/>				Other:_____	<input type="checkbox"/>	<input type="checkbox"/>
Knees	<input type="checkbox"/>	<input type="checkbox"/>	Other:_____	<input type="checkbox"/>	<input type="checkbox"/>			

Physically Active?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Previous Massage?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Good Sleep?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Good Eating Habits	<input type="checkbox"/> Yes	<input type="checkbox"/> No						
Date:_____			Client Signature:_____			Therapist Signature:_____		