

PLEASE INDICATE CONDITIONS YOU ARE CURRENTLY EXPERIENCING OR HAVE EXPERIENCED:

RESPIRATORY

- Chronic Cough
- Shortness of Breath
- Bronchitis
- Asthma
- Emphysema
- Do you smoke? YES NO
How Much? _____
Quit Date: _____

CARDIOVASCULAR

- High / Low Blood Pressure
- Congestive Heart Failure
- Heart Disease
- Heart Attack (date: _____)
- Stroke (date: _____)
- Phlebitis / DVT
- Varicose Veins
- Pacemaker
- Arterio/Atherosclerosis
- Dizziness / Vertigo

OTHER CONDITIONS

- Kidney/Bladder
- Gall bladder
- Liver
- Multiple Sclerosis
- Loss of Sensation
- Diabetes type: _____
- Epilepsy
- Cancer
- Osteoporosis
- Allergies
- Arthritis
Type: _____

HEAD/NECK

- Vision Problems
- Ear Pain / Ringing
- Hearing Loss L R
- Headaches
Migraine / Tension / Sinus

SKIN

- Eczema
- Psoriasis
- Bruise Easily
- Rashes
- Plantar Warts

INFECTIONS

- Hepatitis A B C D
- Tuberculosis (treated: Y N)
- HIV
- AIDS
- Herpes
- Mononucleosis

INJURIES

- Sprains / Strains
Date: _____
Location: _____
- Whiplash
- Dislocation
Date: _____
Location: _____
- Fractures
Date: _____
Location: _____

SOFT TISSUE / JOINT DISCOMFORT

- Jaw R / L
- Neck R / L
- Upper Back R / L
- Mid Back R / L
- Low Back R / L
- Sacroiliac Joint R / L
- Hip R / L
- Legs R / L
- Knees R / L
- Ankles R / L
- Feet R / L
- Shoulder R / L
- Arm R / L
- Elbow R / L
- Wrist R / L
- Hands / Fingers R / L

WOMEN

- Pregnant (DOC: _____)
- Caesarean Section
- Menopausal Problems
- Menstruation Problems
Heavy / Light / Absent / Painful

OTHER HEALTH CARE

- Chiropractic
- Acupuncture
- Naturopath
- Rehab (Physio) Therapy
- Other: _____

FAMILY HISTORY

- Arthritis
Type: _____
- Diabetes
- Cancer
- Other: _____

An accurate health history is important to ensure that it is safe for you to receive Massage Therapy/Reflexology/Craniosacral Therapy and helps the therapist determine a proper treatment plan. All information given before, during and after treatments is held in strict confidence. You are required to inform us of changes in your condition prior to treatment. **I understand that 24 hours notice is required to cancel or full charges will apply. I also understand that if I miss an appointment charges will apply.** I consent to therapeutic massage/reflexology/craniosacral therapy.

Signature: _____ Date: _____

Health History Updated: _____
