



**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		Family History		Family History	
Self		Self		Self	
<b><u>Cardiovascular</u></b>		<b><u>Soft Tissue/Joint Pain</u></b>		<b><u>Other</u></b>	
<input type="checkbox"/>	<input type="checkbox"/> High blood pressure	<input type="checkbox"/>	<input type="checkbox"/> Neck	<input type="checkbox"/>	<input type="checkbox"/> Loss of sensation. Where: _____
<input type="checkbox"/>	<input type="checkbox"/> Low blood pressure	<input type="checkbox"/>	<input type="checkbox"/> Upper back/shoulders	<input type="checkbox"/>	<input type="checkbox"/> Diabetes. Onset: _____
<input type="checkbox"/>	<input type="checkbox"/> Chronic congestive heart failure	<input type="checkbox"/>	<input type="checkbox"/> Arms/hands	<input type="checkbox"/>	<input type="checkbox"/> Allergies. To what: _____
<input type="checkbox"/>	<input type="checkbox"/> Heart attack	<input type="checkbox"/>	<input type="checkbox"/> Mid back	<input type="checkbox"/>	<input type="checkbox"/> Epilepsy
<input type="checkbox"/>	<input type="checkbox"/> Phlebitis/varicose veins	<input type="checkbox"/>	<input type="checkbox"/> Low back	<input type="checkbox"/>	<input type="checkbox"/> Cancer. Where: _____
<input type="checkbox"/>	<input type="checkbox"/> Stroke/CVA	<input type="checkbox"/>	<input type="checkbox"/> Hips	<input type="checkbox"/>	<input type="checkbox"/> Fibromyalgia
<input type="checkbox"/>	<input type="checkbox"/> Pacemaker or similar device	<input type="checkbox"/>	<input type="checkbox"/> Legs	<input type="checkbox"/>	<input type="checkbox"/> Swelling in the ankles
<input type="checkbox"/>	<input type="checkbox"/> Heart disease	<input type="checkbox"/>	<input type="checkbox"/> Knees	<input type="checkbox"/>	<input type="checkbox"/> Bruise easily
		<input type="checkbox"/>	<input type="checkbox"/> Feet	<input type="checkbox"/>	<input type="checkbox"/> Arthritis
		<input type="checkbox"/>	<input type="checkbox"/> Other _____	<input type="checkbox"/>	<input type="checkbox"/> Digestive conditions
<b><u>Respiratory</u></b>		<b><u>Infections</u></b>		<input type="checkbox"/>	<input type="checkbox"/> Hemophilia
<input type="checkbox"/>	<input type="checkbox"/> Chronic cough	<input type="checkbox"/>	<input type="checkbox"/> Hepatitis	<input type="checkbox"/>	<input type="checkbox"/> Osteoporosis
<input type="checkbox"/>	<input type="checkbox"/> Shortness of breath	<input type="checkbox"/>	<input type="checkbox"/> Skin conditions/rash	<input type="checkbox"/>	<input type="checkbox"/> Mental illness
<input type="checkbox"/>	<input type="checkbox"/> Bronchitis	<input type="checkbox"/>	<input type="checkbox"/> TB	<input type="checkbox"/>	<input type="checkbox"/> Dizziness/Fainting
<input type="checkbox"/>	<input type="checkbox"/> Asthma	<input type="checkbox"/>	<input type="checkbox"/> HIV	<input type="checkbox"/>	<input type="checkbox"/> Other: _____
<input type="checkbox"/>	<input type="checkbox"/> Emphysema	<input type="checkbox"/>	<input type="checkbox"/> Herpes		
<input type="checkbox"/>	<input type="checkbox"/> Smoker?				
<b><u>Head and Neck</u></b>		<b><u>Women</u></b>		<b><u>Gastrointestinal</u></b>	
<input type="checkbox"/>	<input type="checkbox"/> History of headaches	<input type="checkbox"/>	<input type="checkbox"/> Pregnant. Due: _____	<input type="checkbox"/>	<input type="checkbox"/> Diarrhea
<input type="checkbox"/>	<input type="checkbox"/> History of migraines	<input type="checkbox"/>	<input type="checkbox"/> Gynaecological issues. What: _____	<input type="checkbox"/>	<input type="checkbox"/> Indigestion/heartburn
<input type="checkbox"/>	<input type="checkbox"/> Vision problems			<input type="checkbox"/>	<input type="checkbox"/> Constipation
<input type="checkbox"/>	<input type="checkbox"/> Vision loss			<input type="checkbox"/>	<input type="checkbox"/> Other: _____
<input type="checkbox"/>	<input type="checkbox"/> Ear problems				
<input type="checkbox"/>	<input type="checkbox"/> Hearing loss				

WHAT ARE YOUR GOALS FOR MASSAGE THERAPY?