Health History

Registered Massage Therapist
MMD Chiropractic Health Center

<table>
<tr><td colspan="6">The information request below will assist us in treating you safely and effectively. Feel free to ask any questions about the information being requested. Please note that all information below will be kept confidential unless allowed or required by law. Your written consent will be required to release any information gathered.</td></tr>
<tr><td colspan="3">Name:</td><td colspan="3">Date of Birth:</td></tr>
<tr><td colspan="6">Address:</td></tr>
<tr><td colspan="3">City:</td><td colspan="2">Province:</td><td>Postal code:</td></tr>
<tr><td colspan="2">Home phn:</td><td colspan="2">Mobile:</td><td colspan="2">Work:</td></tr>
<tr><td colspan="3">Email:</td><td colspan="3">Preferred method of contact:</td></tr>
<tr><td colspan="6">Occupation:</td></tr>
<tr><td colspan="6">Have you had massage therapy before: □ Yes □ No</td></tr>
<tr><td colspan="6">What for?</td></tr>
<tr><td colspan="6">Did another health care practitioner refer you? □ Yes □ No</td></tr>
<tr><td colspan="6">If yes please provide their name and phone number:</td></tr>
<tr><td colspan="6">Family physician name, phone number and address:</td></tr>
<tr><td colspan="6">Other professionals you see: □Chiropractor □Osteopath □Physiotherapist □Other:</td></tr>
<tr><td colspan="3">Emergency contact:</td><td colspan="3">Phone number:</td></tr>
<tr><td colspan="6">Injury History beginning with most recent. Please include any motor vehicle accidents:</td></tr>
<tr><td colspan="6">Surgery History:</td></tr>
<tr><td colspan="6">Current Medications and the conditions they are treating:</td></tr>
<tr><td colspan="6">Allergies:</td></tr>
</table>

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Please indicate conditions you have experienced past and present. Please note any family history of any of the below.

Cardiovascular:
☐High blood pressure
☐Low blood pressure
☐Chronic congestive heart failure
☐Heart attack
☐Heart disease
☐Heart palpitations/arrhythmia
☐Heart murmur
☐Stroke/CVA
☐Aneurism
☐Angina
☐Blood clots
☐Raynaud's Disease
☐Phlebitis/Varicose vein
☐Poor circulation
☐Pacemaker or other device

Respiratory:
☐Chronic cough
☐Shortness of breath
☐Bronchitis
☐Asthma
☐Emphysema
☐Pneumonia
☐Tuberculosis
☐Sinusitis
☐Sinus congestion
Do you smoke? Yes ☐No

Blood:
☐Anemia
☐Haemophilia
☐ Bruise easily
☐Leukemia
☐Hepatitis A B C

Gastrointestinal:
☐Constipation
☐Diarrhea
☐Gas/bloating
☐Nausea/Vomiting
☐Irritable Bowel Syndrome
☐Crohn's / Colitis
☐Hernia
☐Ulcers
☐Gallbladder problems
☐Liver problems/disease
☐Kidney problems/disease
☐Bladder problems
☐Urinary problems
☐Low appetite
☐Excessive thirst

Skin:
☐Allergies:
☐Hypersensitivities
☐Rashes
☐Eczema
☐Psoriasis
☐Athletes foot
☐Herpes
☐Warts
☐Skin conditions:

Women:
☐Pregnant, Due:
☐Infertility
☐Menstrual or vaginal pain
☐Menopausal concerns
☐Endometriosis
☐Fibroids
☐Hysterectomy

Head and Neck:
☐Headaches
☐Migraines
☐Whiplash
☐Jaw pain
☐Ear pain
☐Hearing problems or loss
☐Vision problems or loss

Muscle and joints:
☐Muscle strain:
☐Ligament sprain:
☐Spasms/cramps
☐Tendinitis
☐Bursitis
☐Fibromyalgia
☐Ankylosing Spondylitis
☐Arthritis OA RA
☐Osteoporosis
☐Herniated disc
☐Degenerative disc disease
☐Bone or joint disease
☐Scoliosis
☐Dislocation
☐Fracture:

Other conditions:
☐Diabetes, onset:
☐HIV/AIDS
☐Cancer, type:
☐Multiple Sclerosis
☐Epilepsy
☐Thyroid disoders
☐Lupus
☐Fainting/dizziness
☐Loss of sensation, where:

Lifestyle:
Regular Exercise: ☐Yes ☐Mostly ☐Some ☐No
Drink enough water: ☐Yes ☐Mostly ☐Some ☐No
8 hours of sleep: ☐Yes ☐Mostly ☐Some ☐No
Good eating habits: ☐Yes ☐Mostly ☐Some ☐No

General health:

Mental Health:
☐High stress life: ☐Currently ☐Historic
☐Healthy coping strategies
☐Depression/anxiety
☐Addiction

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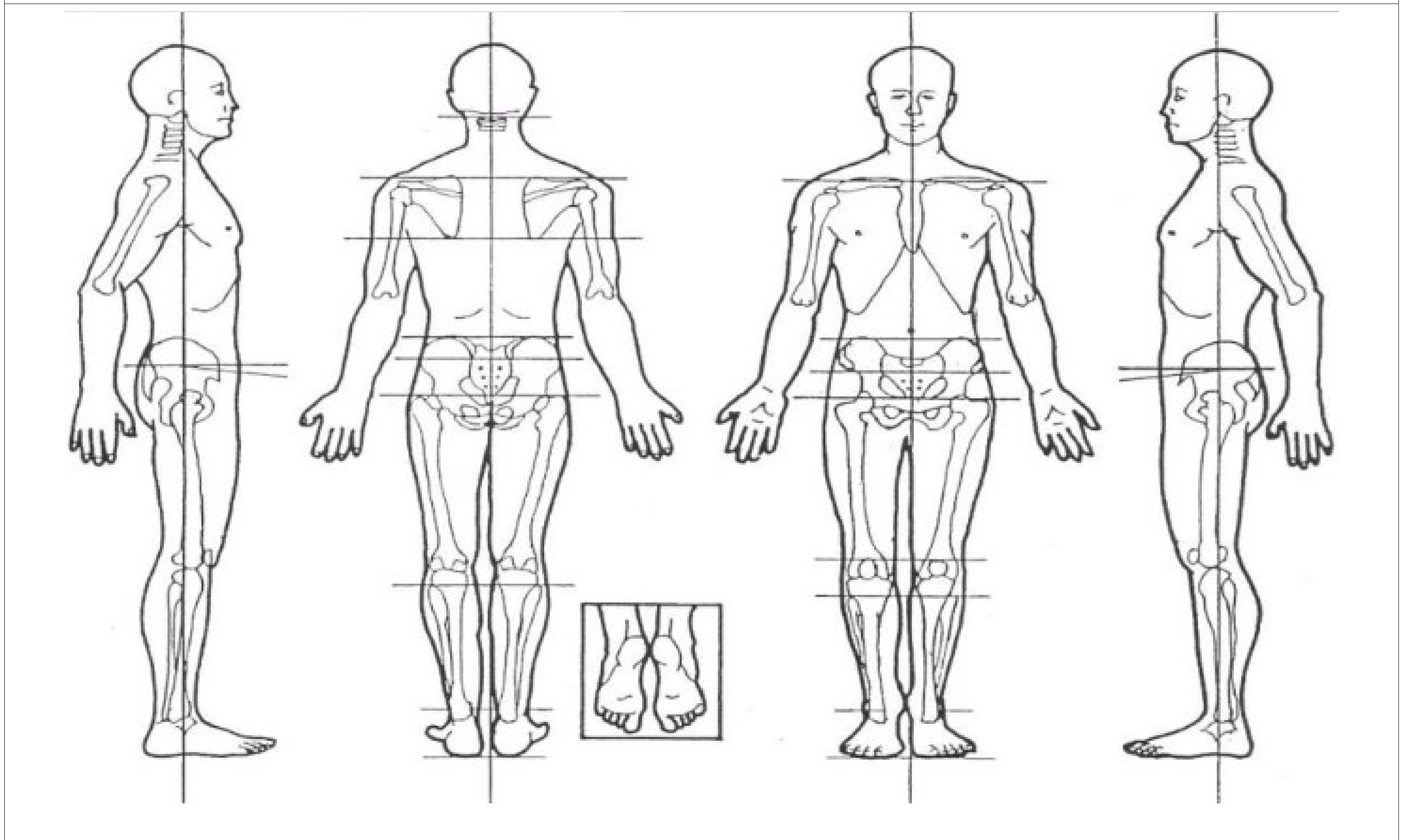
Please use this space to provide details about why you are seeking massage therapy today.

Primary Complaint:

Use the image below to draw your complaint and highlight areas of concern.

Legend: |||tension/stffness +++pain ***numbness ^^^pins/needles/tingling ###heat/swelling



Anything else you would like to add can be put in this space.