Confidential Health History Form

Name: _____ Today's Date: _____
(day/month/year)

Address: _____
Number and Street City Province Postal Code

Telephone (H) _____(W) _____(C) ___ _____

Email Address: _____

Date of Birth: _____Occupation: _____
(day/month/year)

Doctor's Name: _____Telephone: _____

Doctor's Address: _____
Number and Street City Province Postal Code

Emergency Contact: _____Telephone: _____

Referred by:_____

Health History Update (Office Use Only)

Date:	Initials	Date:	Initials
1. _____	_____	3. _____	_____
2. _____	_____	4. _____	_____

Have you received Massage therapy before? Yes ☐ No ☐ If yes, how often? _____

What brings you for a massage today? _____

General Health Status: Poor ☐ Fair ☐ Good ☐

Current Medications/Vitamins/Supplements:

Name: Condition:

_____

_____

_____

_____

Please indicate if any of the following apply to you now or in the past:

Injuries: (sprains, strains, fractures, dislocations)

Type: Date:

_____

_____

_____

Surgery:

Type: Date:

_____

_____

Of Special Note: (pacemaker, pins, wires, artificial joints,limbs, or special equipment: walkers, canes, etc.)

_____

Exercise or Other Recreation:

Type: _____ Frequency: _____

_____

_____

_____

Have you received any of the following treatments?

☐ **Physiotherapy:** Name: _____

Condition: _____ Date: _____

☐ **Chiropractic:** Name: _____

Condition: _____ Date: _____

☐ **Psychotherapy:** _____

Condition: _____ Date: _____

☐ **Other(s)**: (Naturopath, Acupuncturist, Homeopath, Osteopath, etc.)

Name: _____ Condition: _____ Date: _____

Name: _____ Condition: _____ Date: _____

Please indicate if these conditions are current (C) past (P), or if there is a family history (F).

Back, Neck and Head

C	P	F		C	P	F		C	P	F	
☐	☐	☐	tension headaches	☐	☐	☐	whiplash	☐	☐	☐	sinus conditions
☐	☐	☐	migraine headaches	☐	☐	☐	head trauma/concussion	☐	☐	☐	tooth pain
☐	☐	☐	vision loss	☐	☐	☐	back pain/injury	☐	☐	☐	jaw pain
☐	☐	☐	hearing loss	☐	☐	☐	degenerating discs	☐	☐	☐	ear pain
☐	☐	☐	dizziness	☐	☐	☐	sciatica	☐	☐	☐	tinnitus
☐	☐	☐	neck pain/injury	☐	☐	☐	scoliosis				

Limbs (shoulders, feet, arms, hands, hips, legs, feet)

C	P	F	
☐	☐	☐	strains/sprains _____
☐	☐	☐	pain/weakness/tingling/numbness _____
☐	☐	☐	muscle/nerve disease _____
☐	☐	☐	hip pain _____
☐	☐	☐	tendinitis/bursitis _____
☐	☐	☐	fibromyalgia _____

Heart/Circulation

C	P	F		C	P	F		C	P	F	
☐	☐	☐	high blood pressure	☐	☐	☐	phlebitis	☐	☐	☐	stroke
☐	☐	☐	low blood pressure	☐	☐	☐	chest pain/angina	☐	☐	☐	heart disease
☐	☐	☐	bruise easily	☐	☐	☐	heart attack				
☐	☐	☐	cold hands/feet	☐	☐	☐	chronic obstructive heart failure (COPD)				

☐☐☐ swelling: _____

Lungs/Respiration

C	P	F		C	P	F		C	P	F	
☐	☐	☐	asthma	☐	☐	☐	allergies	☐	☐	☐	smoking
☐	☐	☐	bronchitis	☐	☐	☐	frequent colds	☐	☐	☐	emphysema
☐	☐	☐	chronic cough	☐	☐	☐	shortness of breath				

Skin

C	P	F		C	P	F		C	P	F	
☐	☐	☐	open sores/cuts	☐	☐	☐	skin condition/disease	☐	☐	☐	rash/irritations
☐	☐	☐	warts	☐	☐	☐	athlete's foot – type _____				

Digestion/Urogenital Systems

C	P	F		C	P	F		C	P	F	
☐	☐	☐	difficult digestion	☐	☐	☐	rapid weight loss	☐	☐	☐	kidney/urinary
☐	☐	☐	constipation (chronic)	☐	☐	☐	ulcers	☐	☐	☐	bladder bloating/gas
☐	☐	☐	diarrhea (chronic)	☐	☐	☐	liver/gall bladder				

Women

C	P	F		C	P	F	
☐	☐	☐	menstrual issues	☐	☐	☐	menopausal issues

☐☐☐ pregnancy – dates/due date: _____

☐☐☐ other: _____

Men

C	P	F		C	P	F	
☐	☐	☐	prostrate issues	☐	☐	☐	other: _____

General Symptoms

C	P	F		C	P	F		C	P	F	
☐	☐	☐	osteoporosis	☐	☐	☐	anxiety	☐	☐	☐	insomnia
☐	☐	☐	nausea	☐	☐	☐	stress	☐	☐	☐	loss of co-ordination
☐	☐	☐	fatigue	☐	☐	☐	changes in appetite	☐	☐	☐	epilepsy
☐	☐	☐	diabetes: Type: _____								
☐	☐	☐	osteo/rheumatoid arthritis – location _____								

Use this space to elaborate on any of the above conditions: _____

_____

_____

Are there any other medical conditions to bring to my attention? (cancer, haemophilia, infectious diseases, i.e. tuberculosis, hepatitis, HIV, herpes, etc.): _____

_____

Please share anything you feel it is important for me to know in order to give you the best possible treatment.

_____

_____

_____

_____

_____

The information that you give on this form is confidential. No consultation with another health care professional will occur without your prior authorization except where required by law.

Cynthia DeRoche will offer suggestions for assessment and treatment based on your health, comfort, and treatment goals. You have the right to stop the treatment or to ask for a change in assessment and/or treatment at any time and for any reason.

Cancellation Policy

There is a 24 hr cancellation policy. If you miss, cancel or change an appointment with less than 24 hours notice you may be charged the stipulated cancellation fee. (See posted fee schedule) If you are late for a session, you will be charged for the full appointment time scheduled and your session will be shortened to respect the next scheduled client.

Privacy Policy

As a Health Information Custodian (HIC) under Ontario's Personal Health Information Privacy Act (2004), Cynthia is bound by law and ethics to safeguard your privacy and the confidentiality of your personal information. The privacy policy can be found at cynthiaderoche.com in the forms/policies section.

I, _____, have filled out this health history form as completely and thoroughly as possible. I have read and agree with the cancellation policy.

Date: _____ Signature: _____
day/month/year