Cedargrove Massage Therapy Clinic
101 – 200 Kennevale Dr., Nepean, ON K2J 6B6

Date: _____

Name: _____

Client Health History

An accurate health history is important to ensure that it is safe for you to receive a massage treatment.
Please feel free to ask any questions about the information being requested.
If your health status changes in the future, please let us know. All information gathered for this Treatment is confidential except as required or allowed by law or to facilitate diagnosis (assessment) or treatment.
You will be asked to provide written authorization before any of your Personal information can be released.

Email:

Your Address: _____	**Insurance Provider:** _____
Phone #: (H) _____ **(W)**	**Primary Care Physician:** _____
Date of Birth: _____	
Occupation _____	**Physician's Address (if possible):** _____
Who Referred You (if other than your Physician)?	
	Physician's Phone #: _____
Primary reason for your visit today:	**Date of last Physical Exam:** _____
	Were you referred by this Physician? Yes__ No__

Medication(s) You Are Taking	**What condition does this medication treat?**
(Current)	
(Previous Medication)	
Injuries/Accidents	**When did this Injury/Accident Happen?**
Surgery(ies)	**When did you have this Surgery?**

Are you currently receiving treatment from another health care professional? Y __ N__

If Yes, for what? _____

If massage therapy is indicated for you, what goals would you like to achieve in your treatments?

Medical Information

Please check any of the following conditions that apply to you and / or your family members. Please indicate which Family member is involved if / when applicable (ie. M – Mother, F – Father).

__Known Allergies/
Hypersensitivity Reaactiolns
Where the response is anaphylaxis or
Skin irritation. (Please list):

__Allergies (Please List):

__Diabetes (type/Onset):

__Cancer
__Arthritis (type):
__Epilepsy
__Skin Conditions (Please list):

Infectious Conditions
__Skin conditions (Please list):

__TB
__Hepatitis

__Herpes

Cardiovascular Conditions
__High or Low Blood Pressure
__Chronic congestive Heart Failure
__Heart Disease
__History of myocardial infarction
__Phlebitis
__History of Stroke
__Pacemaker or similar device
__Rapid or Slow heart beat
__Nose bleeds
__poor circulation
__Other (please list):

Respiratory Conditions
__Chronic Cough
__Shortness of Breath
__Bronchitis
__Asthma
__Emphysema

Do You Smoke? _____

Digestive Conditions
__Nausea
__Vomiting
__Heartburn
__Belching
__Bloody Stool
__Constipation

Neurological Conditions
__Loss of sensation / numbness:
Numbness
__arms
__hands
__legs
__feet
__Loss of vision or Blurred vision
__dizziness
__hearing loss
__ringing in ear(s)

__Pregnancy (Trimester) __

Overall, how is your general health?

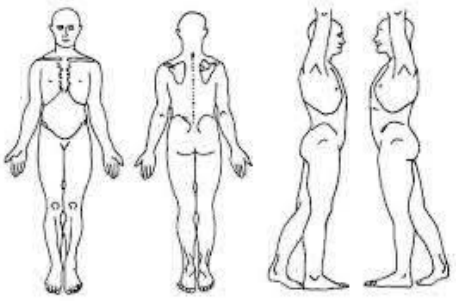
Other Diagnosed Diseases or Medical Conditions ie.
__Gynaecological Conditions
__Hemophilia
__Varicose veins
__Osteoporosis
__Headaches or Migraines
__Fatigue or Chronic Fatigue
__Weight loss
__Sinus trouble
__Depression
__Other (please list):

Surgery & pain
__Soft tissue or joint disomfort
(please mark location)

__Stiffness (please mark location):

__Surgical implants, pins, wires
__Artificial joints
__Swelling
__Hernia

Please mark your area of chief complaint below:



To the best of my knowledge, the information I have provided is complete nd accurate. I will inform the therapist of any changes in my personal or health history.

Date

Client / Substitute Decision Maker: Print

Therapist's Signature

Client / Substitute Decision Maker: Signature