Eastern Passage Wellness Center Health History Form

Name (please print):_____ Date of Birth: _____

Address: _____ City: _____Postal Code: _____

Phone: (H): _____ (W): _____(C): _____Email: _____

Occupation: _____ Regular hobbies/sports/activities: _____

Physician name/address/phone: _____

Current Medications (including non-prescription):_____

_____

Have you ever been in a motor vehicle accident? YES/NO (please circle) Date of accident: _____

Internal pins/wires/artificial joints: _____

How did you find out about the clinic? _____

What is your primary complaint? _____

Can you describe it, (please circle)? DULL SHARP SHOOTING ACHY NUMB TINGLING STIFF

Pain scale: (low) 1----------5----------10 (high) Does it radiate anywhere? _____

Does anything aggravate your symptoms? _____

Does anything relieve your symptoms? _____

When did your symptoms begin? _____

Have your symptoms changed & how? _____

Is this condition interfering with (please circle): WORK SLEEP DAILY ROUTINE ACTIVITIES

(Please explain)_____

Have you seen any other health care practitioner regarding this complaint? Medical Doctor ◯ Chiropractor ◯
Physiotherapist ◯ Massage Therapist ◯ Other ◯ _____

Have they provided results? _____

Please check all that apply:

HEAD/NECK

- □ Headache
- □ Migraine
- □ Visual Disturbances
- □ Contact lenses/glasses
- □ Earaches
- □ Hearing Problems
- □ Jaw Pain/Dental Problems
- □ Whiplash

CARDIOVASCULAR

- □ High blood pressure
- □ Low blood pressure
- □ CCHF
- □ Poor circulation
- □ Heart Disease
- □ Stroke
- □ Pacemaker
- □ Heart attack

RESPIRATORY

- □ Asthma
- □ Chronic cough
- □ Shortness of breath
- □ Bronchitis
- □ Emphysema
- □ Smoker

DIGESTIVE/URINARY

- □ Difficult Digestion
- □ Constipation
- □ Liver/Gallbladder
- □ Kidney/Urinary
- □ Diabetes
- □ Hypoglycemia
- □ Crohn`s Disease
- □ IBS

SKIN

- □ Bruise easily
- □ Eczema
- □ Psoriasis
- □ Varicose Veins
- □ Loss of sensation (Please specify)_____

INFECTIOUS CONDITIONS

- □ Tuberculosis
- □ HIV
- □ Hepatitis Type: _____
- □ Infectious skin conditions:_____

MUSCLE/JOINTS

- □ Neck
- □ Low back
- □ Mid back
- □ Upper back
- □ Shoulder
- □ Hip
- □ Knee
- □ Ankle

FEMALE

- □ Menstrual problems
- □ Pregnancy *Due Date:* _____
- □ Menopausal problems
- □ Gynaecological conditions

OTHER

- □ Hemophiliac
- □ Epilepsy
- □ Cancer
- □ Location:_____
- □ Arthritis OA___ RA___
- □ Fibromyalgia
- □ Osteoporosis
- □ Chronic Fatigue Syndrome
- □ Scoliosis
- □ Carpal tunnel syndrome
- □ Fainting/dizziness/loss of consciousness
- □ Hernia

This is to confirm & acknowledge that the above mentioned information is correct and accurate to my knowledge and that I give consent for my treatment by a Registered Massage Therapist. I also acknowledge the policy that appointments missed or cancelled with less than 24 hour notice will be subject to a $25.00 charge.

Signature: _____ Date: _____