Health History Form

The information request below will assist us in treating you safely. Feel free to ask any questions about the information being requested. Please note that all information provided below will be kept confidentially unless allowed or required by law. Your written permission will be required to release any information.

Name: _____ Phone # _____
Address: _____
Occupation: _____ Date of Birth: _____
Have you received massage therapy before? ☐ Yes ☐ No
Did a health care practitioner refer you for massage therapy? ☐ Yes ☐ No
If yes, please provide their name and address. _____
_____

Please indicate conditions you are experiencing or have experienced:

Cardiovascular
- ☐ high blood pressure
- ☐ low blood pressure
- ☐ chronic congestive heart failure
- ☐ heart attack
- ☐ phlebitis / varicose veins
- ☐ stroke/CVA
- ☐ pacemaker or similar device
- ☐ heart disease

is there a family history of any of the above? ☐ Yes ☐ No

Respiratory
- ☐ chronic cough
- ☐ shortness of breath
- ☐ bronchitis
- ☐ asthma
- ☐ emphysema

is there a family history of any of the above? ☐ Yes ☐ No

Infections
- ☐ hepatitis
- ☐ skin conditions
- ☐ TB
- ☐ HIV
- ☐ herpes

Other Conditions
- ☐ loss of sensation, where? _____
- ☐ diabetes, onset: _____
- ☐ allergies/hypersensitivity to what? _____ type of reaction: _____
- ☐ epilepsy
- ☐ cancer, where? _____
- ☐ skin conditions, what? _____
- ☐ arthritis

is there a family history of arthritis? ☐ Yes ☐ No

Head/Neck
- ☐ history of headaches
- ☐ history of migraines
- ☐ vision problems
- ☐ vision loss
- ☐ ear problems
- ☐ hearing loss

Women
- ☐ pregnant, due: _____
- ☐ gynaecological conditions, what? _____

Overall, how is your general health?
_____

Primary Care Physician:
_____
Address:
_____
_____

Current Medications:
_____
condition it treats: _____
_____

Are you currently receiving treatment from another health care professional? ☐ Yes ☐ No
If yes, for what? _____
_____

Surgery – date _____
nature: _____

Injury – date _____
nature: _____

Do you have any other medical conditions? (e.g. digestive conditions, haemophilia, osteoporosis, mental illness) ☐ Yes ☐ No
what? _____

Do you have any internal pins, wires, artificial joints or special equipment ? ☐ Yes ☐ No
what? _____
where? _____

What is the reason you are seeking massage therapy? Please include the location of any tissue or joint discomfort.
_____
_____
_____

Notes:

Date of initial Health History: _____
Update 1 _____
Update 2 _____
Update 3 _____
Update 4 _____

INFORMED CONSENT

REGISTERED ACUPUNCTURE

Please read this information carefully, and ask your therapist if there is anything that you do not understand

I, the undersigned, do hereby give my voluntary consent for the administration of medical acupuncture and other ancillary techniques as deemed appropriate by my treating therapist.

Acupuncture has been explained to me as a therapeutic treatment performed by the insertion of the single use sterile disposable needles. The needles are inserted through the skin, into the underlying muscles and tissues at specific points on the body for the purpose of alleviating pain, relieving pressure on nerves, improving mobility and re-establishing normal function.

Ancillary techniques of acupuncture may include one or more of the following:

- Electro-acupuncture, where the needles are electrically stimulated at various frequencies to increase therapeutic benefit
- Dry needling, where muscles are briefly needled by an acupuncture needle, held in a needle holder, to release trigger points and spasms
- Cupping – where suction cups are applied to specific points or regions of the body

I understand that there is the possibly of temporary complication which result from the above listed procedures, which include, but limited to, minor bleeding, bruising, soreness, nausea, weakness, individual may experience an infection, convulsion or stuck needles.

I further state that the following do not exist in my current state of health and I will immediately notify the practitioner of any changes:

Pregnancy	Local infections	Pacemaker
Anticoagulants	Bleeding disorders	Elevated risk of infections

I do not expect the acupuncture practitioner to be able to anticipate and explain all possible risks and complications.

I wish to rely on the therapist, to exercise proper judgement during the course of the treatment to make decisions based upon my best interests.

I accept the fact that there is no guarantee of the effectiveness of the treatment. I am aware that I may withdraw this consent and discontinue treatment at any time.

Statement of Consent: I hereby certify that I have read the above information and have had my questions answered to my satisfaction. By signing below, I agree to the above mentioned acupuncture procedures.

Date: Patient name(print): Patient signature: Therapist: