CONFIDENTIAL HEALTH HISTORY INTAKE FORM

PERSONAL INFORMATION Date: _____

_____ Last Name | _____ First Name | _____/_____/_____ D.O.B. (dd/mm/yyyy) | ☐ Male ☐ Female

_____ Mailing Address | _____ City | _____ Postal Code

_____ Phone (Home) | _____ Phone (Cell) | _____ Email Address

_____ Occupation | _____ Emergency Contact Name | _____ Emergency Contact Phone

_____ Doctor's Name | _____ Doctor's City / Phone

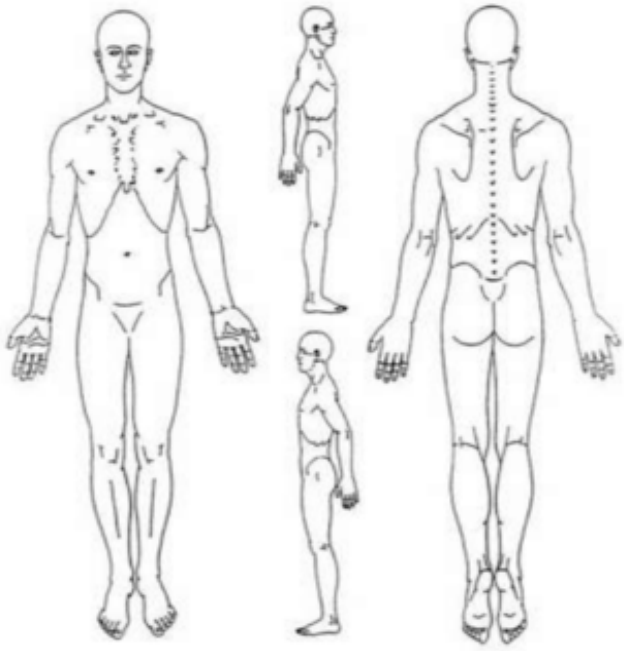
Have you received massage therapy before? ☐ Yes ☐ No

CURRENT HEALTH STATUS

What is the primary reason you are seeking massage therapy?
(Please indicate all locations of your pain or discomfort on the diagram)

_____

_____



Circle all that apply in describing your pain sensation:

Achy Stiff Dull Numb Tingling Sharp Shooting
Throbbing Burning

This discomfort is affecting your:

Work activity / sport home life sleep

Rate pain level: 1 low – 10 high _____

General health level: 1 low – 10 optimal _____

Daily stress level: 1 low – 10 high _____

Are you currently seeking treatment from other health care professionals?

If yes, for what?

_____ ☐ Medical Doctor

_____ ☐ Physiotherapist

_____ ☐ Chiropractor

_____ ☐ Naturopath

_____ ☐ Acupuncture

Current Medications / Supplements:

Name:	Reason for use:

Signature : _____