

# Health History Form

This information is to help the therapist create a safe and effective treatment plan.

Name: \_\_\_\_\_

Today's Date: \_\_\_\_\_

Address: \_\_\_\_\_

Date of Birth: \_\_\_\_\_

City: \_\_\_\_\_ Postal Code: \_\_\_\_\_

Occupation: \_\_\_\_\_

Phone: ( ) \_\_\_\_\_ Cell: ( ) \_\_\_\_\_

Work Phone: ( ) \_\_\_\_\_

Email Address (optional): \_\_\_\_\_

Physician: \_\_\_\_\_

How did you hear about Stillpoint Massage Therapy? \_\_\_\_\_

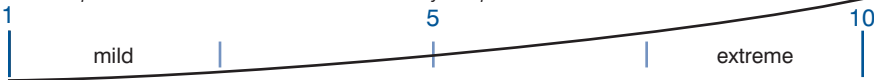
Physician Phone: ( ) \_\_\_\_\_

What is your chief complaint? \_\_\_\_\_

Care Card Number: \_\_\_\_\_

## PAIN SCALE –

Please put an "x" on the scale to indicate your present level of discomfort.



ICBC or  WCB Claim #: \_\_\_\_\_

Extended Medical: yes  no

Insurer: \_\_\_\_\_

Please check  conditions you are experiencing and  conditions you have experienced in the past.

### SKIN

- Eczema
- Psoriasis
- Rashes / bruise easily
- Other skin conditions: \_\_\_\_\_

### MUSCLES / JOINTS

Indicate left (L) or right (R) where appropriate

- Neck  Wrist
- Upper back  Hand
- Mid back  Hip
- Lower back  Leg
- Shoulder  Knee
- Elbows  Ankle
- Arm  Foot
- Weakness or loss of strength
- Clumsiness
- Osteoarthritis
- Rheumatoid arthritis
- Osteoporosis
- Tendinitis: \_\_\_\_\_
- Location: \_\_\_\_\_
- Date: \_\_\_\_\_
- Joint sprain / dislocation: \_\_\_\_\_
- Location: \_\_\_\_\_
- Date: \_\_\_\_\_
- Other injury: \_\_\_\_\_

### PREGNANCY

Trimester: 1st  2nd  3rd

### RESPIRATORY

- Asthma  Bronchitis
- Chronic cough  Difficult breathing
- Emphysema  Shortness of breath
- Smoking  Chronic Sinusitis
- Other: \_\_\_\_\_

### CARDIOVASCULAR

- Bleeding disorder
- High / low blood pressure: \_\_\_\_\_
- Heart attack  Heart disease
- Angina  Pacemaker
- Varicose Veins  Phlebitis
- Poor circulation  Aneurysm
- Stroke / cerebrovascular accident
- Other: \_\_\_\_\_

### HEAD / NECK

- Visual impairment: \_\_\_\_\_
- Hearing impairment: \_\_\_\_\_
- Speech impairment: \_\_\_\_\_
- Head injury: \_\_\_\_\_
- Spinal injury: \_\_\_\_\_
- Headache / migraine
- Jaw pain (temporomandibular joint {TMJ} pain)

### GASTROINTESTINAL

- Constipation  Diarrhea
- Irritable bowel  Colitis
- Hernia  Ulcers
- Other: \_\_\_\_\_

### OTHER CONDITIONS

- Fibromyalgia
- Chronic pain please describe \_\_\_\_\_
- Kidney disease  Cancer
- Diabetes  Fever
- Seizures  Epilepsy
- Insomnia  Stress
- Fainting  Nausea
- Numbness / tingling: where? \_\_\_\_\_
- Allergies (medications, foods, seasonal, oils, lotions, etc.) \_\_\_\_\_

### INFECTIOUS CONDITIONS

- Hepatitis
- HIV
- TB
- Other: \_\_\_\_\_

### FRACTURE:

Location: \_\_\_\_\_  
Date: \_\_\_\_\_

### SURGERY:

Location: \_\_\_\_\_  
Date: \_\_\_\_\_  
 Rods / pins / plates / shunts  
 Implants  
 Transplants

**MOTOR VEHICLE ACCIDENT:** no  yes

Symptoms: \_\_\_\_\_  
\_\_\_\_\_  
Date: \_\_\_\_\_

**MEDICATIONS** currently taking: *Why?*

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

### FAMILY HISTORY OF MEDICAL CONDITIONS:

*If yes, please list:* \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**OTHER HEALTH CARE** received:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

I understand that my personal and medical information is confidential and will only be disclosed to third parties with my permission.  
I also understand that my appointment time has been reserved for me and if I need to cancel or reschedule, 24 hours notice is required, or a cancellation fee may apply.

Signature: \_\_\_\_\_

Date: \_\_\_\_\_