Gleeson Clinic **Massage/Acupuncture Health History**

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Please complete this form in full. The information will assist us in treating you safely. Feel free to ask any questions about the information being requested. All information is kept confidential. Your written consent will be required before release of any personal or medical information unless required by law.

General Information:

Name: ______________________________ Date: ______________

Address: ______________________________ Birth Date: ____________

City: ______________ Province: ________ Postal Code: __________

Preferred Phone: ____________ Emergency Contact: ______________ and Phone: __________

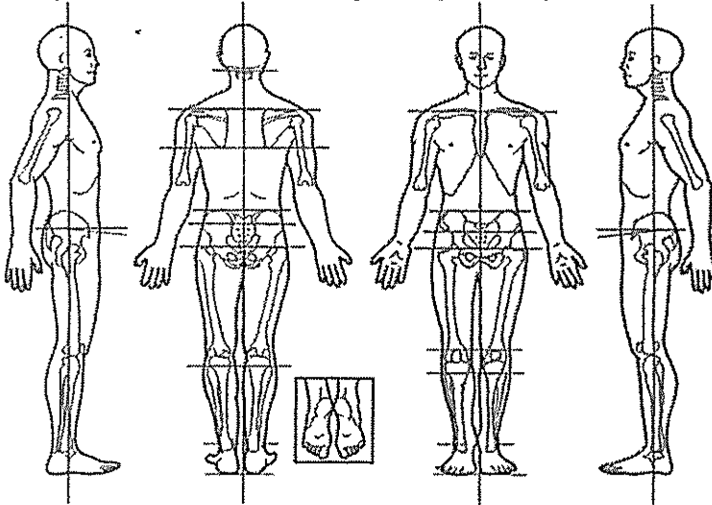
Occupation: ____________________ Have you had massage before?: __________

How did you hear about our clinic? ________________________________

List major complaints in order of importance:

	Complaint	Since	Causes
1			
2			
3			

Circle problem areas on diagram, past or present:



Please describe: (eg. stabbing, aching, tight...):

____

____

____

Diagnostic tests (eg. Xray):

____

Care for these areas with other practitioners?
Explain:______________________________

____

____

Do these complaints interfere with your:

sleep? Hours sleep / night: ____ times waking ____ What wakes you?____________________

activities of daily living? Explain: ______________________________

____

Exercise: How often do you exercise? ______________________________

What form of exercise? ______________________________

How long do you exercise? ______________________________

How would you rate your stress level? (0-10): ____/10 **General Health**: ☐poor ☐fair ☐good ☐ excellent

Medical History

Physician: ______________ Address: ____________________ Phone: __________

Date of last physical: ______________ Are you pregnant? ______ Due date? ____________

Medications: Are you taking any blood thinners, or medications for blood pressure, pain...?:

	Medication	Date started	What it treats
1			
2			
3			

Please list any of the following that apply to you:

Allergies: (to medications, foods, environmental....)

____

Major Accidents, Injuries, or Falls, Surgeries or Implants (pacemakers, prosthesis, wires, etc.) Include year:

____

____

Hospitalizations or illnesses and the year: ______________________________

____

Please check any condition that applies to you, past or present:

- ☐ spasms or cramping
  Where? ______________
- ☐ hernia
  Where? ______________
- ☐ reflux / heartburn
- ☐ herniated discs:
  Which ones? ______________
- ☐ numbness / tingling
  Where? ______________
- ☐ arthritis: ☐ RA ☐ OA
  Where?: ______________
- ☐ bone and joint pain
- ☐ swelling (eg. gland, leg)
  Where? ______________
- ☐ osteoporosis / osteopenia
- ☐ diabetes: onset: ______________
- ☐ hypoglycaemia
- ☐ fatigue / poor endurance
- ☐ ulcer
- ☐ large or sudden weight loss or gain
- ☐ breast lumps / pain
- ☐ cancer
  Where? ______________
  Stage? __________
- ☐ kidney infections / stones
- ☐ gallbladder problems
- ☐ liver disease
- ☐ nausea/vomiting
- ☐ digestive problems (eg. constipation, diarrhea…)
  Explain: ______________
- ☐ bladder infection
- ☐ urinary problems: circle: burning / frequent / bloody
- ☐ incontinence / leaking with eg.coughing

Skin

- ☐ bruise easily
- ☐ skin conditions, eg. change in mole, open sores, rashes, warts, psoriasis, eczema, athlete's foot...
  Explain: ______________
  ____

Head and neck

- ☐ concussion or whiplash
  When? ______________
- ☐ tension headaches
  How often? ______________
- ☐ migraines
  How often? ______________
- ☐ eye/ vision / nose / sinus / ear / hearing problems:
  What? ______________
- ☐ tooth / jaw / TMJ problems

- ☐ tinnitus / sounds in ears
- ☐ dizziness or vertigo
- ☐ epilepsy
- ☐ confusion
- ☐ anxiety
- ☐ depression
- ☐ stroke / CVA / TIA

Respiratory

- ☐ difficult breathing
- ☐ chronic cough
- ☐ asthma
- ☐ other conditions; eg. emphysema, bronchitis, TB,..
  What? ______________

Cardiovascular

- ☐ high blood pressure
- ☐ low blood pressure
- ☐ heart disease
- ☐ heart attack / MI
- ☐ heart palpitations / arrhythmias
- ☐ chest pains / angina
- ☐ varicose veins
- ☐ aneurism, thrombosis, or clots

Other conditions / diagnoses past or present:

eg. haemophilia, scoliosis, fibromyalgia, AS, ALS, MS, Raynaud's, IBS, endometriosis, fibroids, tumours, chicken pox, shingles...:

____

____

I certify that the information given in this form is true and accurately reflects my past and present health status. I will notify my Massage Therapist if there is any change in my condition.

Client's Signature ______________________________ Date ______________