Gleeson Clinic ***Massage/Acupuncture Health History***

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***Please complete this form in full. All information is strictly confidential.***

**General Information**

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

 Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Birth Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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

 Preferred Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Alternate Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Height: \_\_\_\_\_\_\_\_\_\_\_\_ Weight: \_\_\_\_\_\_\_\_\_\_\_ Max. Weight: \_\_\_\_\_\_\_\_\_\_\_ When: \_\_\_\_\_\_\_\_\_\_

 Occupation: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Have you had massage before: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 How did you hear about our clinic? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Focus** *List major complaints in order of importance.*

|  |  |  |
| --- | --- | --- |
| Complaint | Since | Causes |
| 1 |  |  |  |
| 2 |  |  |  |
| 3 |  |  |  |

**Review of Symptoms** *Only mark if a problem, 1=occasional difficulty 2=frequent difficulty 3=regular difficulty*

 1 2 3 1 2 3 1 2 3

 🞎 🞎 🞎 weight loss or gain 🞎 🞎 🞎 fevers 🞎 🞎 🞎 gas

 🞎 🞎 🞎 fatigue 🞎 🞎 🞎 dizziness 🞎 🞎 🞎 abdominal pain

 🞎 🞎 🞎 hair loss 🞎 🞎 🞎 ringing in ears 🞎 🞎 🞎 nausea/vomiting

 🞎 🞎 🞎 sexual difficulties 🞎 🞎 🞎 earaches 🞎 🞎 🞎 difficult digestion

 🞎 🞎 🞎 poor endurance 🞎 🞎 🞎 blurry vision 🞎 🞎 🞎 fatty foods aggravate

 🞎 🞎 🞎 confusion 🞎 🞎 🞎 eyestrain 🞎 🞎 🞎 constipation

 🞎 🞎 🞎 nervousness 🞎 🞎 🞎 nasal congestion 🞎 🞎 🞎 diarrhea

 🞎 🞎 🞎 depression 🞎 🞎 🞎 sinus pressure 🞎 🞎 🞎 thin stool

 🞎 🞎 🞎 insomnia 🞎 🞎 🞎 nosebleeds 🞎 🞎 🞎 straining

 🞎 🞎 🞎 nightmares 🞎 🞎 🞎 hayfever \_\_\_\_\_ number of bowel

 🞎 🞎 🞎 muscle tension 🞎 🞎 🞎 swollen glands movements daily

 🞎 🞎 🞎 muscle cramps 🞎 🞎 🞎 mucous problems \_\_\_\_\_ is this a change (y/n)

 🞎 🞎 🞎 numbness/tingling 🞎 🞎 🞎 sores in mouth 🞎 🞎 🞎 hemorrhoids

 🞎 🞎 🞎 cold hands/feet 🞎 🞎 🞎 coated tongue 🞎 🞎 🞎 bloody or black stools

 🞎 🞎 🞎 sweaty hands/feet 🞎 🞎 🞎 bad breath 🞎 🞎 🞎 night urination

 🞎 🞎 🞎 blackouts 🞎 🞎 🞎 sore throats 🞎 🞎 🞎 urinary problems

 🞎 🞎 🞎 itching 🞎 🞎 🞎 dental problems 🞎 🞎 🞎 burning on urination

 🞎 🞎 🞎 rashes 🞎 🞎 🞎 neck pains 🞎 🞎 🞎 bladder/kidney infection

 🞎 🞎 🞎 acne 🞎 🞎 🞎 cough 🞎 🞎 🞎 bedwetting

 🞎 🞎 🞎 eczema 🞎 🞎 🞎 difficult breathing 🞎 🞎 🞎 blood in urine

 🞎 🞎 🞎 psoriasis 🞎 🞎 🞎 shortness of breath 🞎 🞎 🞎 back pains

 🞎 🞎 🞎 warts 🞎 🞎 🞎 coughing blood 🞎 🞎 🞎 leg swelling

 🞎 🞎 🞎 change in mole 🞎 🞎 🞎 heart palpitations 🞎 🞎 🞎 bone or joint pain

 🞎 🞎 🞎 bruise easily 🞎 🞎 🞎 chest pains 🞎 🞎 🞎 arm/leg problems

 🞎 🞎 🞎 headaches 🞎 🞎 🞎 breast lumps/pain 🞎 🞎 🞎 joint swelling

Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Medical History**

Personal Physician: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_

 Date of last physical: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 Are you pregnant? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ What is your due date?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 Are you allergic to medicines? Which ones? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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

 Are you allergic to foods? Which ones? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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

 Are you allergic to the environment? What? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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

 Please list any regular medications, prescriptions or over the counter, that you take: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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

 Please list any regular vitamin, mineral or herbal supplements you take: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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

Please list any pacemakers, prothesis, implants, pins or wires: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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

 Please list any major operations you have had, and the year: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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

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

 Please list any major injuries or accidents that you have had, and the year: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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

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

 Please list any major illnesses or hospitalizations that you have had, and the year: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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

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

 *Write the approximate year that you have incurred any of the following conditions:*

 \_\_\_\_ anemia \_\_\_\_ drug reaction \_\_\_\_ hypoglycaemia \_\_\_\_ parasite

 \_\_\_\_ arthritis \_\_\_\_ eczema \_\_\_\_ jaundice \_\_\_\_ pneumonia

 \_\_\_\_ asthma \_\_\_\_ emphysema \_\_\_\_ kidney infection \_\_\_\_ psoriasis

 \_\_\_\_ bladder infection \_\_\_\_ epilepsy \_\_\_\_ kidney stones \_\_\_\_ rheumatic fever

 \_\_\_\_ blood transfusion \_\_\_\_ gallstones \_\_\_\_ LB pressure \_\_\_\_ skin boils

 \_\_\_\_ bronchitis \_\_\_\_ heart attack \_\_\_\_ measles, German \_\_\_\_ syphilis

 \_\_\_\_ cancer \_\_\_\_ heart disease \_\_\_\_ measles, regular \_\_\_\_ tuberculosis

 \_\_\_\_ chicken pox \_\_\_\_ hepatitis \_\_\_\_ mental problems \_\_\_\_ ulcer

 \_\_\_\_ colitis \_\_\_\_ HB pressure \_\_\_\_ migraines \_\_\_\_ whooping cough

 \_\_\_\_ diabetes \_\_\_\_ HIV/AIDS \_\_\_\_ mumps

 \_\_\_\_ diphtheria \_\_\_\_ hives \_\_\_\_ obesity

 Any other medical diagnosis you have from the past or present: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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

**Exercise Information**

 How often do you exercise weekly? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 What form of exercise? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 How long do you exercise? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**I certify that the information given in this form is true and accurately reflects my past and**

**present health status.**

Client’s Signature \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_