Please indicate the conditions that you have experienced or are currently experiencing:

Cardiovascular:
- ☐ High Blood Pressure
- ☐ Low Blood Pressure
- ☐ Congestive Heart Failure
- ☐ Heart Attack
- ☐ Phlebitis / Varicose Veins
- ☐ Stroke / CVA
- ☐ Pacemaker or similar device
- ☐ Heart Disease
- ☐ Dizziness / Vertigo
- ☐ Seizures
- ☐ Hemophilia

Head and Neck:
- ☐ Headaches
- ☐ Migraines
- ☐ Vision Problems
- ☐ Vision Loss
- ☐ Ear problems
- ☐ Hearing Loss
- ☐ Jaw Pain

Infectious Conditions:
- ☐ Skin Conditions

Describe:_____

_____

- ☐ Respiratory Conditions:

Describe:_____

_____

- ☐ Hepatitis
- ☐ HIV
- ☐ AIDS
- ☐ Herpes

Respiratory:
- ☐ Asthma
- ☐ Bronchitis
- ☐ Emphysema
- ☐ Chronic Cough
- ☐ Shortness of Breath

Muscle / Joint:
- ☐ Neck
- ☐ Back (lower)
- ☐ Back (mid)
- ☐ Back (upper)
- ☐ Shoulders
- ☐ Elbow
- ☐ Wrist / Hand
- ☐ Hip
- ☐ Knee
- ☐ Ankle / Foot
- ☐ Spine
- ☐ Jaw

Women:

Chance of Pregnancy? Y / N

Due Date:_____

- ☐ Gynecological Conditions

List:_____

_____

- ☐ Menstrual Problems
- ☐ Menopausal Problems

Digestive:
- ☐ Constipation
- ☐ Crohn's Disease
- ☐ Colitis
- ☐ Irritable Bowel Syndrome
- ☐ Ulcers

Skin Conditions:
- ☐ Eczema
- ☐ Psoriasis
- ☐ Rash
- ☐ Warts
- ☐ Open Sores

Other:
- ☐ Loss of Sensation

Where?_____

- ☐ Diabetes

Onset:_____

Type:_____

- ☐ Epilepsy
- ☐ Seizures
- ☐ Cancer

Type/Location:_____

- ☐ Arthritis
- ☐ Osteoporosis
- ☐ Mental Illness
- ☐ Fibromyalgia
- ☐ Chronic Fatigue
- ☐ Scoliosis
- ☐ Polio / Post polio

Is there a family history of any of the above? Please list:

_____

_____

Do you have any other medical conditions or additional information that you would like to provide?

_____

_____

WAIVER:

Because massage is contraindicated under certain conditions, I affirm that all information provided in this health history form is complete and correct to the best of my knowledge. I agree to inform my massage therapist of any changes to my medical profile, and I understand that I will be asked to update this health history form yearly, at a minimum.

_____ _____

Signature **Date**

kw health connection

chiropractor • naturopath • massage

(for office use only)

Date: _____ Chart No. _____

Update 1: Update 2:

Update 3: Update 4:

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

Name: Last _____ First _____ Initial _____

Address _____

City _____ Prov. _____ Postal _____

Phones (H) _____ (W) _____ Cell _____

Age ___ Date of Birth (D/M/Y) _____ / _____ / _____ Sex (M) ___ (F) ___

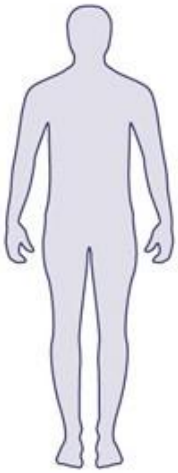
Occupation _____

Email _____

(email addresses will only be used for appointment reminders and monthly newsletters)

Emergency Contact _____ Phone _____

Do you have 3rd party Extended Health Benefits through work or otherwise? Y/N



FRONT

Have you ever had Massage Therapy before? Y / N When? _____

What is your main reason for seeking Massage Therapy today? (Please be as specific as possible with any complaints or concerns you have).

| mark on diagram to right using the letter key below the diagrams |

Please circle the number that best describes your pain

0 1 2 3 4 5 6 7 8 9 10

none mild moderate severe

Did a health care practitioner refer you for massage therapy? Y / N

If yes, please provide their name and address _____

_____

Are you currently receiving treatment from another health care professional? Y/N

If yes, for what? _____

Physician name and address _____

_____

Do you have any of the following? Please circle.

Internal Pins Wires Artificial Joints Special Equipment

Do you have any allergies? _____

Are you taking any medications? _____

_____

What condition(s) do they treat? _____

_____

List any and all previous injuries, surgeries, or illnesses, including the date:

_____

_____

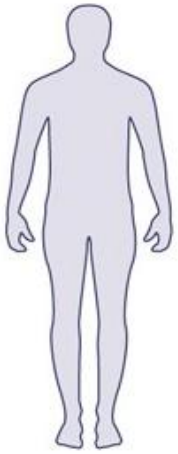
Will you be filing a WSIB claim due to a work related accident? Y / N

If yes, Claim # _____ Adjusters Name _____

Have you been in a recent Auto accident? Y / N If so, will you or have you already made an Auto Insurance claim? Y / N Claim # _____

Adjuster Name _____ Phone _____

How did you hear of '**kw health connection**'? _____



BACK

Please mark on the image above the areas of:

Pain (X) Burning (B)

Numbness (/) Ache (A)

Weakness (O) Stiffness (#)

(To be taken by your massage therapist)

Blood Pressure:

Date:

(PLEASE SEE REVERSE SIDE)