



ReAlign Health Clinic

2445 Eagle St. N.
Cambridge, ON N3H 4R7
(519)650-1630

Registered Massage Therapy

Health History:

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

Name: _____

Date: _____

Address: _____

Email: _____

City: _____

Occupation: _____

Postal Code: _____

Home Telephone: _____

Family Physician Information:

Alternate Telephone: _____

Name: _____

Date of Birth: _____

Address: _____

mm/dd/year

Postal Code: _____

Telephone: _____

Extended Health Care Coverage: Yes No

Name of Provider: _____

Annual Benefit Amount for Massage Therapy: \$ _____

Did someone refer you for Massage Therapy at our clinic? _____

Have you had massage therapy before? Yes No Frequency: _____

Reason for coming? Relaxation/Stress Reduction Pain Relief Other

What is your primary complaint? _____

Has there been a medical diagnosis? If yes, what is it? _____

Have you had any traumatic injuries? (car accidents, falls, dislocations, surgeries etc). If yes, please explain: _____

Current Medications: _____

Conditions it Treats: _____

Please check any of the symptoms you are experiencing and add any not mentioned which are significant to you. Sometimes a symptom, which seems trivial can supply a key to providing relief.

Head

History of Headaches

Type: _____

Frequency: _____

Injury

Details: _____

Vertigo

Vision Loss/Vision Problems

Jaw Pain/TMJ Dysfunction

Sinus

Hearing Loss or Ear Problems

Other: _____

Respiratory

Chronic Bronchitis

Frequent Colds

Chronic Cough

Shortness of Breath

Asthma

Emphysema

Other: _____

Family History of any of the above

Women

Menstrual Problems
Heavy / Painful / Light

Pregnant / Due Date: _____

No. of Children _____

Miscarriage

Menopause

Hysterectomy

Breast Cancer

Other: _____



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Health History Update:

For Office Use Only

- 1. _____ 4 _____
- 2. _____ 5. _____
- 3. _____ 6. _____

Vasculature

- Leg Cramps
- Varicose Veins
- Poor Circulation
- Phlebitis
- Raynaud's Syndrome
- Atherosclerosis
- Other: _____

Muscles/Joints

- Stiffness
- Neck Pain
- Low Back Pain
- Mid Back Pain
- Upper Back Pain
- Shoulder Pain
- Leg Pain: Left / Right
- Knee Pain: Left / Right
- Other: _____

Other Conditions

- Insomnia
- Cancer
Where: _____
- Epilepsy
- HIV
- Allergies
To What: _____
- Thyroid Imbalance
- Hepatitis
Type: _____
- Psychological: _____
- Hemophilia
- Constipation
- IBS
- Crohn's Disease/Colitis
- Diabetes
Type: _____
- Other: _____

Neurological

- Fainting Spells
- Blackouts
- Seizures
- Paralysis
- Weakness
- Numbness
- Tingling
- Tremors
- Loss of Sensation
Where: _____
- Other: _____

Skin

- Rashes
- Sores
- Infectious Skin Condition
- Herpes
- Eczema
- Psoriasis
- Scars
- Other: _____

Presence of:

- Pins
- Wires
- Artificial Joints
- Special Equipment
- Screws
- Plates
- Other: _____

Current or Past Involvement with Other Practitioners:

- Chiropractic Yes No
- Physiotherapy Yes No
- Personal Trainer Yes No
- Previous Massage Yes No
- Acupuncture Yes No
- Naturopathic/Homeopathic Yes No
- Osteopathy Yes No
- Other: _____ Yes No

Cardiac

- Pacemaker/Similar Device
- Heart Disease/CCHF
- High Blood Pressure
- Low Blood Pressure
- Hear Attack
- Stroke/CVA
- Other: _____

Arthritis

- Rheumatoid
- Osteoarthritis
- Systemic Lupus
- Psoriatic
- Reiter Syndrome
- List Affected Areas:

Family History of Arthritis

- Yes No

Good Sleeping Patterns

- Yes No

Regular Eating Habits

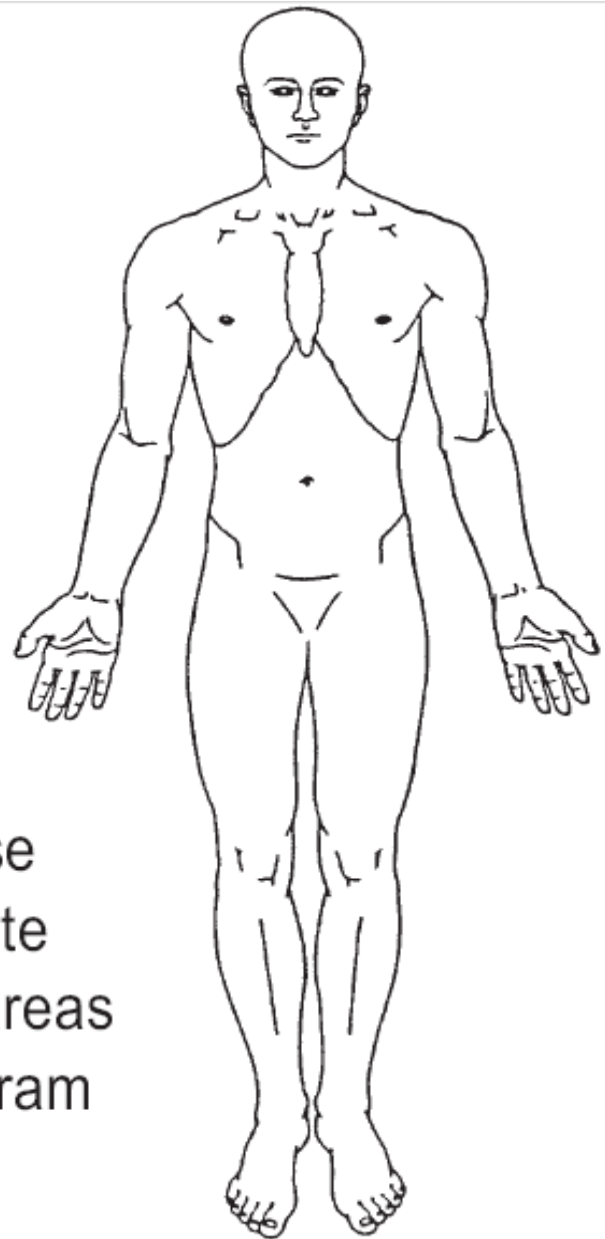
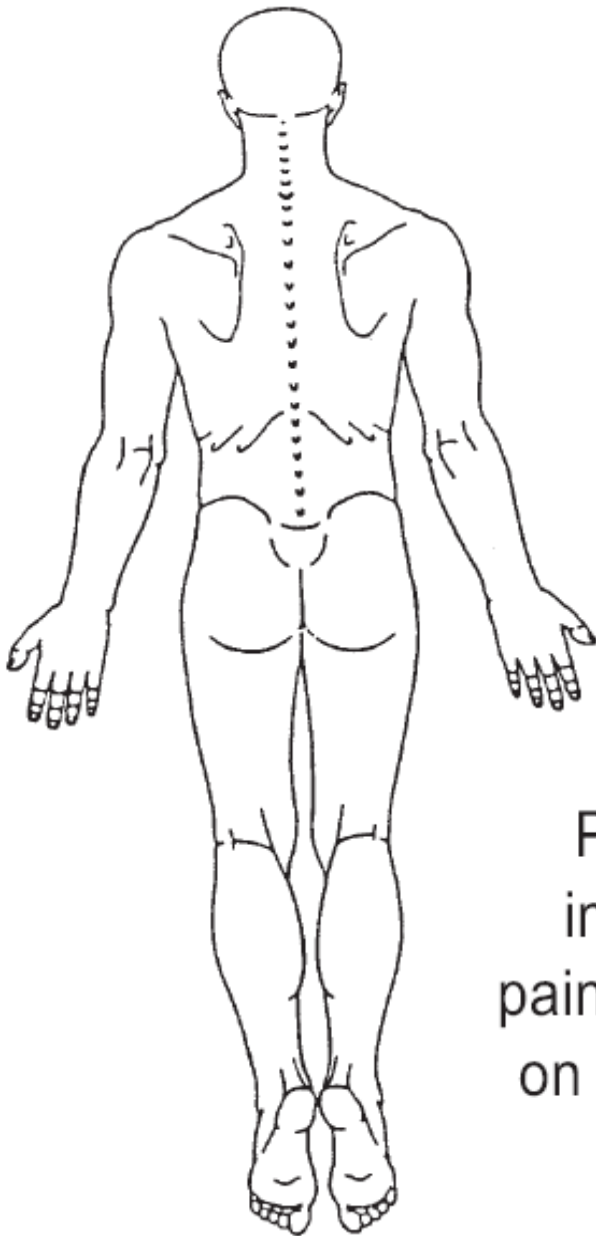
- Yes No



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Please
indicate
painful areas
on diagram