



A Total Approach to Health and Wellness

### HEALTH HISTORY: MASSAGE / ACUPUNCTURE / TCM

(Please answer all questions, even if they seem unrelated to your case.)

Name: \_\_\_\_\_  
Address: \_\_\_\_\_  
City: \_\_\_\_\_ Prov: \_\_\_\_\_  
Postal Code: \_\_\_\_\_  
Phone (H): \_\_\_\_\_ (W): \_\_\_\_\_  
(C): \_\_\_\_\_

Date: \_\_\_\_\_  
Family Physician: \_\_\_\_\_  
Address: \_\_\_\_\_  
Phone: \_\_\_\_\_  
Emergency Contact: \_\_\_\_\_  
Phone: \_\_\_\_\_

E-Mail Address: \_\_\_\_\_ Check if you want to receive any of the following through e-mail:

- Appointment Reminders  Health Newsletters  Special Offers  Special Events

#### How did you find out about us?

- Healthcare Provider  Lawyer  Employer  Clinic Materials
- Special Event  Here Before  Website  Special Offer
- Can Pages  Yellow Pages  Family/Friends  Signage

Who referred you? \_\_\_\_\_

Female  Male Birth date: \_\_\_\_\_

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

Do you smoke?  No  Yes  
If yes, how much per day: \_\_\_\_\_

Medication/Vitamins	Condition

Are you, or are you possibly pregnant?

- No  Yes

Expected due date: \_\_\_\_\_

Do you exercise regularly?  No  Yes

Frequency: \_\_\_\_\_x/week

Do you have any internal pins, wires, artificial joints or other special equipment (such as a pacemaker or hearing aid)?  No  Yes

If yes, please explain: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

When was your last treatment? massage \_\_\_\_\_ acupuncture \_\_\_\_\_ TCM \_\_\_\_\_

Have you ever been in a motor vehicle accident, sustained an athletic injury or other trauma?

No  Yes Please give a date and description of your injuries: \_\_\_\_\_

Have you ever been hospitalized?  No  Yes Have you ever had surgery?  No  Yes

Date and description: \_\_\_\_\_

What is the purpose of your visit? \_\_\_\_\_

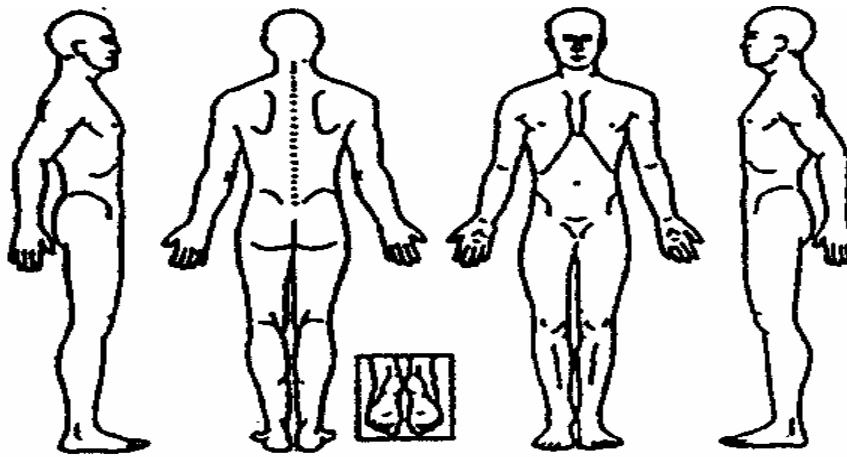
What started this condition? \_\_\_\_\_

When did this condition begin? \_\_\_\_\_

Have you received treatment from other healthcare providers for this condition?  No  Yes

If yes, who are they and what type of healthcare provider are they: \_\_\_\_\_

**PLEASE TURN OVER AND COMPLETE THE OTHER SIDE**



Please circle the areas on the diagram above where you feel discomfort.

**Have you been diagnosed with, or have you ever experienced any of the following?**

If **Yes**, please mark with a “**C**” for current issues and “**P**” for past on the line provided.

**General**

- Cancer/Tumors
- Diabetes
- Kidney problems
- Liver problems
- Drug/Alcohol addiction
- Infectious conditions (hepatitis, HIV, etc.)
- Eating disorder
- Loss of vision/ hearing
- Headaches/ Migraines
- Numbness or tingling

- Bronchitis
- Asthma
- Emphysema
- Shortness of breath

- Bursitis

**Skin**

- Sensitivities to oils, lotions, detergents
- Other allergies or hypersensitivities
- Irritated skin conditions
- Contagious conditions ie. Warts/ rashes.
- Frostbite
- Lack of sensation
- Inflammation

**Nervous system**

- Epilepsy
- Multiple sclerosis
- Cerebral palsy
- Parkinson’s
- Nerve lesion
- Sciatica
- Carpal tunnel syndrome

**Circulatory/Respiratory**

- Chronic congestive heart failure
- Heart disease
- Other heart condition
- High blood pressure
- Low blood pressure
- Varicose veins
- Deep vein thrombosis
- Chronic cough

**Musculoskeletal**

- Scoliosis
- Bone or joint disease
- Arthritis
- Joint instability
- Tendonitis
- Fractured bones
- Jaw pain (TMJ)
- Whiplash

**For Women Only**

- Pregnancy
- P.M.S.
- Menstrual Cramps
- Recent abortion or vaginal birth

**Have you ever suffered from a:**

Heart Attack?  No  Yes Date: \_\_\_\_\_ Stroke?  No  Yes Date: \_\_\_\_\_

**Please list any other condition not listed & provide details as necessary**

\_\_\_\_\_

**WAIVER:** I hereby release the Practitioner from any and all liability from problems arising from any treatment as a result of information not given or given incorrectly in this case history. I also agree to advise my Practitioner of any pertinent condition that may arise after or during the treatment period.

\_\_\_\_\_  
(Signature)

\_\_\_\_\_  
(Date)