HEALTH HISTORY FORM
Ocean Heart Wellness Centre
Hillary Pitts, RMT

Personal Information

Name: ____ DOB: _______________________

Address: _________________________________ City: ________________ Postal Code: __________

Cell Phone: _________________ Work Phone: ________________ Occupation: _________________

Email: ____ May I contact you through email? YES or NO

Doctor: ______________________________Phone: __________________ Dr. Referral? YES or NO

Emergency Contact: _________________________________ Number: _________________________

Extended Health Care: Do you consent to direct billing for Massage Therapy Treatments? YES or NO

Blue Cross: Policy #______________________ ID #_____________________________

Manulife: Policy #_______________________ ID #_____________________________

Canada Life: Policy #_____________________ ID #_____________________________

Have you had Massage Therapy before? YES or NO

Do you see other Alternative Health providers? (please circle) Acupuncturist, Physiotherapist,

Chiropractor, Osteopath, Naturopath, Other ________________________ Frequency: ____________

Primary Complaint today: ____

When did this complaint begin? ____

Aggravating factors: ______________________________ Relieving Factors: _____________________

Describe Symptoms (circle all that apply) Dull, Achy, Sharp, Burning, Throbbing, Numb, Other ________

Pain Scale (least) 0 1 2 3 4 5 6 7 8 9 10 (most) Frequency: Occasional, Frequent, Constant

Injuries/ Accidents: ____

Surgeries (dates incl): ____

Current Medications/ Supplements: ____

Other Medical Conditions (ie: hemophilia, diabetes, arthritis) __________________________________

Please indicate all conditions you have experienced. Mark C for current or P for past.

Joint/ Soft Tissue Discomfort:

___ Arms
___ Upper Back
___ Mid Back
___ Lower Back
___ Degenerative Discs
___ Feet
___ Hands
___ Hips
___ Jaw
___ Knees
___ Legs
___ Neck
___ Osteo Arthritis
___ Rheumatoid Arthritis
___ Sciatica Limitation of Movement
___ Shoulders
In which joints: _____________
Other_____________________

Skin:

___ Rashes
___ Itching
___ Bruise Easily
___ Dryness
___ Boils
Other ________________

Reproductive:

___ Pregnant. Due date _________
___ Painful Menstruation
___ Heavy Flow
___ Irregular Cycle
___ Swollen Breasts
___ Menopausal
___ Pre-menopausal
___ Post-menopausal
___ Birth Control. Type_________

General Symptoms:

___ Fainting
___ Dizziness
___ Loss of Sleep
___ Fatigue
___ Nervousness
___ Sudden Weight loss/ gain
___ Numbness
___ Tingling
___ Paralysis
___ Headaches (tension)
___ Migraines

Cardiovascular:

___ High Blood Pressure
___ Low Blood Pressure
___ Coronary Heart Disease
___ Heart Attack
___ Phlebitis
___ Stroke/ CVA
___ Pacemaker
___ Heart Murmur
___ Palpitations
___ Varicose Veins
___ Swelling of the Ankles
___ Poor Circulation

Respiratory:

___ Chronic Cough
___ Bronchitis
___ Asthma
___ Hay Fever
___ Difficulty Breathing
___ Smoking
___ Emphysema
___ Pneumonia

Infections:

___ Hepatitis
___ Tuberculosis
___ HIV
___ Herpes
___ Cold
___ Flu
___ Athlete's Foot
___ Warts
Other ______________

Digestive:

___ Poor Appetite
___ Belching/ Gas
___ Constipation
___ Diarrhea
___ Nausea
___ Ulcer
___ Vomiting

Eye, Ears, Nose, Throat:

___ Allergies
___ Frequent Colds
___ Glasses/ Contacts
___ Hearing Loss
___ Hearing Aid
___ Sinus Infection
___ Swollen Glands

Lifestyle Questions

Regular eating habits ◯Yes ◯No
Energy Level ◯High ◯Average ◯Low
Do you take vitamins ◯Yes ◯No Type: _______________________________ Frequency: ____________________
Regular exercise ◯Yes ◯No Type: ___________________________________ Frequency: ____________________
Do you suffer from stress? ◯Yes ◯No Type: ______________________________
How many hours a do you use a computer? ________________________________

Please read carefully and sign.

I attest that the information I have provided is true and complete to the best of my knowledge.
I understand the information I have provided on this form is confidential and will not be released without my written consent.
I consent to therapeutic massage treatment by the above named massage therapist.
I also understand that I am responsible for charges incurred in the course of my treatment.
I understand that 24hrs notice is required to reschedule all future appointments or full charges will apply.

____
Signature

____
Today's date