Coronation
Chiropractic & Massage

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Confidential Health History Form

An accurate health history is important to ensure that it is safe for you to receive a massage treatment. If your health status changes in the future, please inform your therapist. All information is kept confidential except as required by law. You will be asked to provide written consent for the release of any information.

Name:____________________ Date: ____________________
Address: ________________________________ Email address: ____________________
____

Phone #: H: ____________________ W: ____________ C: ______________

Date of birth: _D/M/Y________________ Occupation: ____________________
In case of emergency, contact name and phone # ________________________________

Name of Physician: ____________________ Physician's phone #: ____________________
Who referred you: ______________________

Present Complaint: __________________________________
Was this the result of accident or specific injury? If so, explain. ____________________

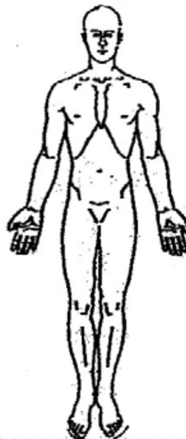
____

Are you currently or have you had any previous treatment for the above complaint by a:

- ☐ Medical doctor
- ☐ Physiotherapist
- ☐ Chiropractor
- ☐ Massage Therapist
- ☐ Other

Please indicate any areas where you are currently experiencing pain, stiffness, numbness or tingling:

P= areas of pain
X= areas of jt/muscle stiffness
S= areas of numbness/tingling
 # = areas of scars, bruises, open wounds



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Previous Injuries/Surgeries/Serious Illness

1. **Date/Type:**________________________ 2. **Date/Type:** ________________________
   Explain: ________________________ **Explain:** ________________________

Please indicate any of the following that apply to you

Respiration

Current	Previous	
( )	( )	Chronic cough
( )	( )	Asthma
( )	( )	Bronchitis
( )	( )	Emphysema

Head / Neck

Current	Previous	
( )	( )	Headaches
( )	( )	Migraines ( ) with aura
( )	( )	Vision problems
( )	( )	Earaches
( )	( )	Hearing loss
( )	( )	Whiplash

Skin

Current	Previous	
( )	( )	Skin condition
	type: ______	
( )	( )	Bruise easily
( )	( )	Plantar warts
( )	( )	Rashes
( )	( )	Psoriasis
( )	( )	Eczema

Cardiovascular

Current	Previous	
( )	( )	High blood pressure
( )	( )	Low blood pressure
( )	( )	Poor circulation
( )	( )	Heart condition
( )	( )	Chest pains
( )	( )	Plebitis
( )	( )	Varicose veins
( )	( )	Atherosclerosis
( )	( )	Stroke
( )	( )	Myocardial Infarction
( )	( )	Pacemaker
( )	( )	Other

specify: ______

Muscle / joint problems

current	Previous	
( )	( )	Neck
( )	( )	Upper back
( )	( )	Middle back
( )	( )	Lower back
( )	( )	Shoulders: left/right
( )	( )	Elbow: left/right
( )	( )	Wrist: left/right
( )	( )	Hand: left/right
( )	( )	Hip: left/right
( )	( )	Knee: left/right
( )	( )	Ankle: left/right
( )	( )	Foot: left/right

Digestive / Urinary

Current	Previous	
( )	( )	Difficult digestion
( )	( )	Constipation
( )	( )	Liver / gall bladder
( )	( )	Kidney / bladder
( )	( )	Crohn's disease
( )	( )	Colitis
( )	( )	Diabetes
	type: ______	
( )	( )	Ulcers

Other Conditions

Current	Previous	
( )	( )	Hemophilia
( )	( )	Epilepsy
( )	( )	Frequent colds
( )	( )	Fibromyalgia
( )	( )	Osteoporosis
( )	( )	Cancer

Location: ______

Date of last check up: ____/____/____

( )	( )	~~Osteoarthritis~~

Location: ______

( )	( )	Rheumatoid arthritis

Location: ______

Surgical Implants

( ) Pins

where: ______

( ) Wires

where: ______

( ) Artificial limbs / joints

( ) Other

Female

Current	Previous	
( )	( )	Menstral problems

Painful ____ Heavy ____ Scant ____

( )	( )	Pregnancy

approx. due date: ____/____/____

( )	( )	Menopausal problems

type: ______

Infectious Conditions

AIDS / HIV ( ) yes ( ) no

Hepatitis ( ) yes ( ) no

type: ______

Infectious skin condition(s)

( ) yes ( ) no

Type/Location: ______

ADDITIONAL INFORMATION:

______

______

______

INFORMED CONSENT

IT IS MY CHOICE TO RECEIVE MASSAGE THERAPY AND I UNDERSTAND THAT THE TREATMENT BEING GIVEN IS FOR THE WELL-BEING OF MY BODY AND MIND. I AGREE TO COMMUNICATE WITH MY THERAPIST ANY TIME I FEEL THAT MY WELL-BEING IS BEING COMPROMISED. I UNDERSTAND THAT THE THERAPIST WILL OUTLINE THE TREATMENT AND WILL COMMENCE TREATMENT ONCE CONSENT HAS BEEN OBTAINED. I UNDERSTAND THAT I MAY STOP THE TREATMENT AT ANY TIME I CHOOSE. I ACKNOWLEDGE THAT MASSAGE IS NOT A SUBSTITUTE FOR MEDICAL EXAMINATIONS OR DIAGNOSIS AND IT IS RECOMMENDED THAT I SEE A PRIMARY HEALTHCARE PROVIDER FOR THAT SERVICE. I UNDERSTAND THAT AT LEAST 24 HOURS NOTICE PRIOR TO CANCELLING AN APPOINTMENT IS REQUIRED OR I WILL BE CHARGED FOR THE MISSED APPOINTMENT.

______ ______

SIGNATURE **DATE**

Please be courteous to other clients and ensure that cellular phones and pagers are turned OFF.

THANKYOU