DATE: _____

THE PARKHILL WELLNESS CLINIC
CONFIDENTIAL HEALTH HISTORY

NAME: _____ HOME PHONE: _____ WORK: _____

ADDRESS: _____ CITY: _____ POSTAL CODE: _____

EMAIL: _____ BIRTHDATE: _____ OCCUPATION: _____

GENERAL HEALTH: ☐ EXCELLENT ☐ GOOD ☐ FAIR ☐ POOR WEIGHT: _____ HEIGHT: _____

PHYSICIAN: _____ PHYSICIAN ADDRESS: _____

DATE OF LAST PHYSICAL EXAM: _____ RESULTS: _____

REFERRED BY: _____ ADDRESS: _____

WHAT BRINGS YOU IN FOR MASSAGE? ☐ RELAXATION ☐ STRESS ☐ INJURY ☐ PAIN

AREAS TO BE TREATED: _____

WHAT HAVE YOU TRIED FOR RELIEF? ☐ HEAT ☐ COLD ☐ EXERCISE ☐ OTHER

☐ PREVIOUS MASSAGE ☐ REGULAR MASSAGE LAST MASSAGE DATE: _____

CHECK BELOW ANY CONDITIONS YOU ARE CURRENTLY EXPERIENCING OR HAVE EXPERIENCED

CIRCULATION

☐ HIGH BLOOD PRESSURE
☐ LOW BLOOD PRESSURE
☐ HEART CONDITION
☐ CCHF
☐ VARICOSE VEINS
☐ POOR CIRCULATION
☐ DIZZINESS
☐ PACEMAKER
☐ PHLEBITIS
☐ HEART ATTACK / STROKE

MUSCLES / JOINTS

☐ ARTHRITIS
☐ BURSITIS / TENDONITIS
☐ FRACTURES
☐ WHIPLASH
☐ NECK PAIN
☐ LOW BACK PAIN
☐ STIFF / SWOLLEN JOINTS
☐ POOR POSTURE
☐ FOOT TROUBLE
☐ TMJ
☐ KNEES / LEGS
☐ ARMS / HANDS

GENERAL

☐ LEFT HANDED
☐ RIGHT HANDED

FOR WOMEN

☐ PMS
☐ PREGNANT
☐ MENOPAUSE
__ NUMBER OF CHILDREN

DIGESTION / ELIMINATION

☐ CONSTIPATION / DIARRHEA
☐ LIVER / GALL BLADDER
☐ DIVERTICULITIS
☐ ULCERS
☐ NAUSEA / GAS

NERVOUS SYSYTEM

☐ NERVOUS / DEPRESSED
☐ FATIGUE
☐ INSOMNIA

IMMUNE SYSTEM

☐ HEPATITIS
☐ TB
☐ HIV
☐ ALLERGIES
☐ FREQUENT COLDS

SKIN

☐ SENSITIVE
☐ RASHES / ERUPTIONS
☐ CONTAGIOUS CONDITION
☐ BRUISE EASILY
☐ OTHER

OTHER

☐ HEADACHES
☐ MIGRAINES
☐ LOSS OF SENSATION
☐ DIABETES
☐ HYPOGLYCEMIA
☐ EPILIEPSY
☐ CANCER
☐ SCIATICA
☐ HEARING LOSS
☐ POOR VISION
☐ ARTIFICIAL JOINTS
☐ INTERNAL PINS
☐ SPECIAL EQUIPMENT
☐ FAMILY HISTORY OF ARTHRITIS

RESPIRATORY

☐ CHRONIC COUGH
☐ SHORTNESS OF BREATH
☐ BRONCHITIS
☐ ASTHMA
☐ EMPHYSEMA
☐ SEASONAL ALLERGIES

SURGERY / HOSPITALIZATION

TYPE: _____
DATE: _____
CURRENT SYMPTOMS:
_____
_____
_____
_____
_____

INJURY / ACCIDENT / FALL

DATE: _____
CURRENT SYMPTOMS: _____
_____
_____
_____
_____

CURRENT MEDICATIONS AND CONDITIONS TREATED

_____
_____
_____
_____
_____
_____

OTHER HEALTH CARE

☐ CHIROPRACTIC
☐ PHYSIOTHERAPY
☐ CUSTOM ORTHOTICS
☐ OTHER (please list below)
_____
_____

SELF-CARE

☐ GOOD SLEEPING HABITS
☐ REGULAR EXERCISE
☐ GOOD EATING HABITS
☐ POSITIVE MENTAL ATTITUDE
☐ OTHER (please list below)
_____

THE PARKHILL WELLNESS CLINIC
Registered Massage Therapy

Your first consultation with the massage therapist may include a review of your health history, a postural analysis and a musculoskeletal screening to determine the most effective treatment. The therapist will discuss with you the clinical findings and will outline an individual treatment plan, which will reflect your desired outcome, type and frequency of treatment and your self-care program. The therapist will monitor your progress and the treatment program will be reviewed on a regular basis. An exercise program, in clinic or at home, may be included in your treatment plan. Proper and adequate information, including potential positive and negative effects, benefits and possible risks associated with certain techniques will be fully discussed with you prior to initiating the treatment plan. Your therapist will require your verbal and written consent for treatment in specific areas such as inner thighs, gluteals, breast and abdomen. (See "Consent for Treatment Of Sensitive Areas" below).

Consent for Treatment

I,_____hereby consent to the massage therapy treatment as prescribed by my massage therapist. The techniques that will be used, their desired effects/possible risks have been explained to me. I understand that my treatment plan may involve a remedial exercise program and I agree to put my maximum effort to complete the required exercises as directed by the therapist. I am aware of my right to have my therapist modify my treatment or withdraw my consent at any time. Unless I give written consent, all information given to the therapist will remain strictly confidential within the clinic. I have read and understand the above information and consent to the treatment as proposed by the massage therapist.

Consent for Treatment of Sensitive Areas

Some medical conditions require treatment to sensitive ares: gluts, medial thigh, breast, or abdomen. If indicated and recommended by your massage therapist, please read and sign below:

I,_____hereby consent to the massage therapy treatment for ☐ gluts, ☐ medial thigh, ☐ breast, and/or ☐ abdomen as recommended by my massage therapist. Techniques, draping, effects and risks have been explained to me. I am aware of my right to have my therapist modify my treatment or withdraw my consent at any time.

Name:_____Date:_____.

Signature:_____.