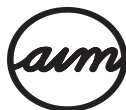

Active Integrative Medicine

Health History Form

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

Name: ____________________ Date: ____________________
Phone (Home) ____________ (Cell Phone) ____________ (Work) ____________
Address____________________Postal Code____________
Occupation: ____________________ Date of Birth: ____________
Email (for reminder calls) ____________________
Have you received massage therapy before? ☐ Yes ☐ No
Who referred you to our clinic? ____________________
Please indicate conditions you are experiencing or have experienced:

Cardiovascular

- ☐ High blood pressure
- ☐ Low blood pressure
- ☐ Chronic congestive heart failure
- ☐ Heart attack
- ☐ Phlebitis/ varicose veins
- ☐ Stroke/CVA
- ☐ Pacemaker or similar device

Is there a family history of any of the above? ☐ Yes ☐ No

Respiratory

- ☐ Chronic cough
- ☐ Shortness of breath
- ☐ Bronchitis
- ☐ Asthma
- ☐ Emphysema

Is there a family history of any of the above? ☐ Yes ☐ No

Infections

- ☐ Hepatitis
- ☐ Skin conditions
- ☐ TB
- ☐ HIV
- ☐ Herpes

Other Conditions

Loss of sensation, where?
____
Diabetes, onset: ____________
Allergies/ hypersensitivity to what?
____
Type of reaction: ____________
Epilepsy
Cancer, where? ____________
Skin conditions, what?
____
Arthritis, what type?
____

Is there a family history of arthritis?
☐ Yes ☐ No

Head/ Neck

- ☐ History of headaches
- ☐ History of migraines
- ☐ Vision problems
- ☐ Vision loss
- ☐ Ear problems
- ☐ Hearing loss

Women

Pregnant, due ____________
Gynaecological conditions,
What? ____________

Overall, how is your health?
____

Primary Care Physician:
____
Address____________________
____

Phone#____________________

Current Medications:
____
Conditions it treats: ____________________
____
Are you currently receiving treatment from another health care professional? ☐ Yes ☐ No
If yes, for what?
____

Surgery- date____________________
Nature:
____
Injury – date____________________
Nature: ____________________

Do you have any other medical conditions? (e.g. digestive conditions, haemophilia, osteoporosis, mental illness) ☐ Yes ☐ No
What? ____________________

Do you have any internal pins, wires, artificial joints or special equipment? ☐ Yes ☐ No
What? ____________________
Where? ____________________

What is the reason you are seeking massage therapy?
Please include the location and if there is any joint discomfort.
____
____

Active Integrative Medicine
780 Kingston Rd, Unit B10 Pickering, ON L1V 0C5
Ph: 905-492-8688 www.theaimclinic.ca