COCOON

REGISTERED MASSAGE THERAPY

BY KENNETH BOONE

HEALTH HISTORY FORM

An accurate health history is important to ensure that it is safe for you to receive a message treatment. All information gathered for this treatment is confidential except as required or allowed by law. Written authorization will be required for release of any information.

24 hour cancellation notice is required otherwise a missed appointment fee will be charged. This form must be updated annually.

First Name : ______________________

Address : ______________________

City : ____________ **Province :** ________

Postal code : ________ **Date of Birth :** ___ /___ /___

Gender: **M** ◯ **F** ◯ **Occupation:** __________

Primary Health Care Physician : __________

Address: ____________ **Tel No:**

Emergency contact Person: ______________

Last Name : ______________________

Tel. Home : ______________________

Tel. Bus : ______________________

Tel. Cell : ______________________

Email : ______________________

◯ **Health Practitioner's Referral :** __________

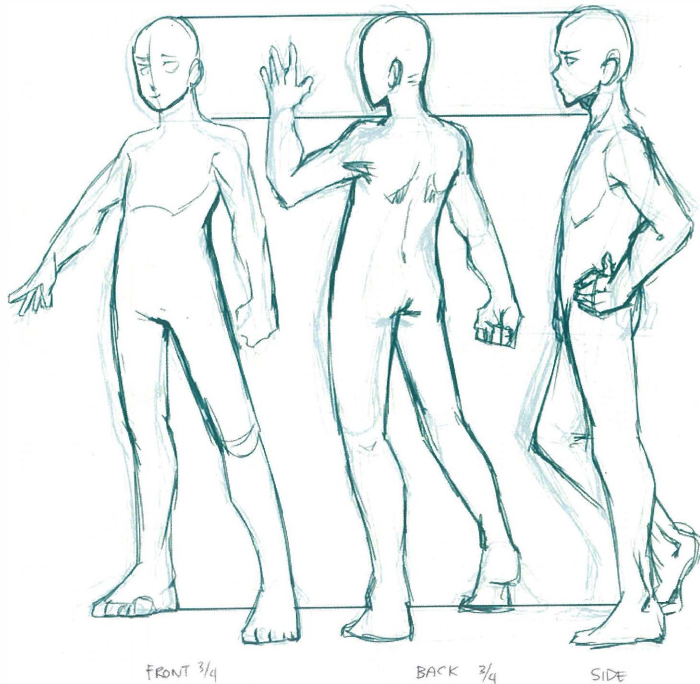
Address of Health Practitioner : __________

◯ **Others Referral:** __________

Emergency Contact Person Tel: __________

1st Massage Therapy Treatment: Y ◯ **N** ◯ **General Health Status:** ______ **Primary Complaint:** __________

Please indicate where you are experiencing any pain, joint and muscle stiffness, numbness and tingling.



Blood Pressure: ______________________

Date: ______________________

Time: ______________________

Surgery

type ______________________

date: ___ /___ /___

current symptoms ______________________

____

____

Present involvement in other Health Care: Yes ◯ **NO** ◯

If yes Specify: ______________________

◯ **Pins / Wires / Prosthetics**: ______________________

◯ **Medical Alert Bracelet** (specify condition / allergy)

____

ACCIDENTAL/INJURY

◯ Car Accident ◯ Work Related ◯ Other

Date: ______________________

Symptoms: ______________________

____

____

Physical Limitations: ______________________

Womens

◯ pregnant / due date: ___ /___ /___

◯ gynecological conditions: ______________________

◯ breast pain: ______________________

◯ cysts

breast lift (date): ___ /___ /___

breast augmentation (date): ___ /___ /___

breast reduction (date) : ___ /___ /___

Please list all medication(s) you may be taking and the condition(s) they are currently treating:

Medications: ______________________ **Conditions:** ______________________

Have you taken any anti-inflammatory medication, pain killer, muscle relaxants, or mood altering medication withing the past 2 hours?

Y ◯ **N** ◯ if YES, what and how much?

Have you had any allergic reacrtion to any medication: **Y** ◯ **N** ◯
if yes, to what? ______________________

For your current condition, have you tried any of the following
◯ Massage ◯ Chiropractic ◯ Physiotherapy ◯ Acupuncture ◯ Osteopath ◯ Yoga ◯ Pilates ◯ Stretching & Exercise

Are you physically active **Y** ◯ **N** ◯
How often ? ______________________
Type of exercise: ______________________

Previous Massage experience: **Y** ◯ **N** ◯
Good sleeping habits **Y** ◯ **N** ◯
Regular eating habits **Y** ◯ **N** ◯

Please indicate conditions you are curently experiencing or have experienced in the past:

Musculoskeletal

(specify its nature: Pain, Stiffiness, Numbness, Spasm)

- ◯ neck ______
- ◯ shoulder ______
- ◯ upper back ______
- ◯ mid back ______
- ◯ low back ______
- ◯ arms ______
- ◯ chest ______
- ◯ legs ______
- ◯ other ______
- ◯ joints (list) ______

Headache History

- ◯ tension ______
- ◯ migraines ______
- ◯ tooth/jaw/ear/pain ______
- ◯ head trauma(date: ______
- ◯ history of headaches
  type: ______
- ◯ other: ______
- ◯ smoker ______

Gastroinstestinal

- ◯ irritable bowel syndrome ______
- ◯ colitis ______
- ◯ gastroenteritis ______
- ◯ crohn's disease: ______
- ◯ contipation ______

Skin

- ◯ skin condition
- ◯ specify ______
- ◯ bruise easily
- ◯ herpes
- ◯ varicose veins
- ◯ athletes foot
- ◯ loss of sensatioin

Respiratory

- ◯ chronic cough
- ◯ shortness of breath
- ◯ bronchitis
- ◯ asthma
- ◯ emphysema
- ◯ pneumonia
- ◯ sinus problems
- ◯ smoker
- ◯ family history of any of above

Cardiovascular

- ◯ high blood pressure
- ◯ low blood pressure
- ◯ heart attack (date: ______
- ◯ phlebitis / DVT
- ◯ stroke / CVA (date\: ______
- ◯ pulmonary emboli
- ◯ pacemaker
- ◯ heart disease
- ◯ angina
- ◯ chronic congestive heart failure
- ◯ family history of any of above

Infectious Disease

- ◯ hepatitis
- ◯ infections skin conditions
- ◯ tuberculosis
- ◯ HIV
- ◯ other: ______

Other Conditions

- ◯ neurological conditions
- ◯ epilepsy
- ◯ diabetes/onset: ______
- ◯ allergies: ______
- ◯ family history of allergies
- ◯ family history of hypersensitivities
- ◯ cancer ______
- ◯ arthritis ______
  type OA/RA/other\: ______
  where: ______
- ◯ family history of arthritis
- ◯ vision loss
- ◯ hearing loss
- ◯ insomnia
- ◯ hemophilin
  kidney/bladder problems
- ◯ overactive bladder
- ◯ osteopenia
- ◯ osteoporosis
- ◯ positional vertigo
- ◯ mental illness: ______
  other: ______

Substitute Decision Marker: **Y** ◯ **N** ◯

Name: ______________________

I have read the above information and have stated all my previous and current medical conditions. I take it upon myself to update the massage therapist regarding any changes in my conditions. I understand that all massage treatments will be discussed and planned with the massage therapist, and will require my informed consent.

UPDATED

Date: ______________________ **Client Signature:** ______________________

Date: ______________________ **Client Signature:** ______________________