

Massage Therapy at Nova Spinal Care Personal information and Health History

Date: _____

Name: _____

Occupation: _____

Address: _____

City: _____ Postal Code: _____

Phone (home): _____ (Business): _____

(Cell): _____

Birthdate: (month): _____ / (day): _____ / (year): _____

Email: _____ Permission to email: _____ (initial)

Sex: (circle one) M F Primary care physician: _____

Currently involved with other Health care practitioners? If so what type?

How did you hear about the clinic? _____

Emergency Contact (Please specify relationship and contact number):

General Health Status:(circle one) poor average above average excellent
Please list current medication(s) that you are taking and condition(s) they are treating. _____

Have you had any injuries or accidents in the past? If so when and what happened?

Any past surgeries? Yes or No, When?

Health History Information:

Please check if any of these apply to you:

Cardiovascular insufficiency

- High/low blood pressure
- Chronic congestive heart failure
- Heart disease
- History of myocardial infarction
- Phlebitis
- History of cerebro-vascular accident
- Pacemaker or similar device

Respiratory insufficiency

- Chronic cough
- Bronchitis
- Shortness of breath
- Asthma
- Emphysema
- Smoker Y or N

Allergies or Hypersensitivity reactions

Please describe: _____

Diabetes type 1 type 2

Arthritis Cancer Epilepsy Skin conditions

Presence of infections conditions including:

- Infections skin conditions
- Tuberculosis
- Hepatitis
- HIV

Women: Pregnant? No Yes Due Date: _____

Anything else we should be aware of? (Other diagnosed diseases or medical conditions?)

The therapist will fill out the remainder:

Chief complaint:

Onset:

Location:

Duration:

Frequency: _____

Intensity: _____

Pain scale: 0 no pain _____ 10 excruciating

Character: _____

Aggravating factors:

Relieving factors:

Associated signs and symptoms: _____
