Julia Wellness Center.

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HEALTH HISTORY FORM

The information on this form will be kept confidential except as required by law. Your written permission will be required to release any information. **It is important to be accurate** so that we can ensure it is safe for you to receive a massage treatment. If your health status or contact information changes in the future, please let us know.

Name: _____ Date of Birth: DD_____/MM_____/YY _____
Mailing Address: _____City:_____Postal Code:_____
Email Address: _____ Date of Today: dd_____/mm_____/yy_____
Telephone: (home) _____(work) _____ (other) _____
Occupation: _____ What is your primary complaint? _____
Extended health care plan? ☐Yes ☐No History of massage therapy? ☐Yes ☐No
Referred by: _____
Please be specific: name of friend, name of doctor, advertisement location, website, etc.

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

HEAD / NECK

☐ headaches
☐ vision problems / loss
☐ contact lenses
☐ earaches
☐ hearing problems
☐ jaw pain / TMJ disorder

RESPIRATORY

☐ chronic cough
☐ shortness of breath
☐ asthma –Date of last attack:_____
☐ bronchitis / emphysema
☐ smoking

CARDIOVASCULAR

☐ CCHF
☐ heart attack
☐ stroke / CVA
☐ pacemaker / similar device
☐ high blood pressure
☐ low blood pressure
☐ heart disease
Type: _____
☐ poor circulation/bruise easily
☐ phlebitis
☐ varicose veins
Dr. diagnosed? ☐yes ☐no

INFECTIONS

☐ herpes
☐ hepatitis
☐ skin condition
Type: _____
☐ TB
☐ HIV / AIDS
☐ other:_____

OTHER CONDITIONS

☐ numbness & tingling
Areas: _____
☐ difficult digestion
☐ constipation / diarrhea
☐ IBS
☐ liver:_____
☐ gallbladder:_____
☐ kidney:_____
☐ diabetes –Type 1 or 2?
Onset:_____
☐ sinus:_____
☐ allergies (anaphylaxis or skin irritation): _____
☐ insomnia/fatigue
☐ depression
☐ cancer:_____
☐ epilepsy –Date of last seizure:_____
☐ osteoporosis
☐ arthritis
Dr. diagnosed? ☐yes ☐no
Areas:_____
Family history? ☐yes ☐no
☐ menstrual problems / pain
☐ pregnancy – Due:_____
☐ menopausal problems:____
_____

OVERALL feeling of general health?_____
_____

OTHER MEDICAL CONDITIONS (including pins, wires, artificial joints or limbs, wheelchair, walker, cane, etc):
_____

CURRENT MEDICATIONS
(including aspirin, herbs, vitamins, etc)
Name Condition
_____ _____
_____ _____
_____ _____
_____ _____
_____ _____
_____ _____

Initial _____

Please list the timing, &nature of ANY injuries,accidents and Alergeries

Type:_____
Date:_____
Current symptoms:_____
Type:_____
Date:_____
Current symptoms:_____
Type:_____

Date:_____
Current symptoms:_____
Type:_____
Date:_____
Current symptoms:_____

MUSCLES & JOINTS

Please indicate where you are currently experiencing pain or stiffness:

- ☐ neck / jaw: right / left
- ☐ shoulders: right / left
- ☐ arms: right / left
- ☐ hands: right / left
- ☐ mid back: right / left
- ☐ low back: right / left
- ☐ thighs: right / left
- ☐ knees: right / left
- ☐ lower legs: right / left
- ☐ ankles: right / left
- ☐ feet: right / left
- ☐ other:

_____

_____

OTHER HEALTH CARE

- ☐ massage therapy
- ☐ chiropractic
- ☐ physiotherapy
- ☐ psychotherapy
- ☐ acupuncture
- ☐ weekly exercise
- ☐ nutritional consultation
- ☐ other:

_____

MEDICAL DOCTOR

Name:

_____

Telephone:

_____

Date of last visit: _____

Address:_____

Permission to send your Doctor a report pertaining to your health care? ☐yes / ☐no
It is important for you to know that you may stop or modify your treatment at any time. Also, it is normal to experience side effects such as muscle achiness and tenderness for a period of up to 48 hours following your massage. Do you consent? ☐Yes / ☐No

If an appointment is missed without 24 hours notice,
Date of initial Health
History : _____
Update 1: _____
Update 2: _____
Update 3: _____
Update 4: _____
Update 5: _____
Update 6: _____
Update 7: _____
you will be billed for the time booked.

Signature:_____

THANK YOU for taking the time to
accurately fill out this health history form