MakCare Health and Wellness Centre

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 or required by law. Your written permission will be required to release any information.

Name: _____ Phone: _____
Address: _____ Email: _____
Occupation: _____
Date of Birth (mm/dd/yyyy): _____
Have you received massage therapy before? ☐ Yes ☐ No
Did a health care practitioner refer you for massage therapy? ☐ Yes ☐ No
If yes, please provide their name and address _____

Person to contact in case of emergency:
Name: _____ Phone: _____

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?

_____
Types of reaction: _____
- ☐ Epilepsy
- ☐ Cancer, where?

_____
- ☐ Skin condition, what?

_____
- ☐ Arthritis

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 general health?
_____

Primary Care Physician
_____
Address: _____
_____
_____
Phone: _____

MakCare Health and Wellness Centre
2 Chokecherry Crescent, Markham, ON, L6E 0J6
Tel: (647) 992-6992
Email: info@makcare.com - www.makcare.com

☐ Current Medications: _____ _____ Condition it treats: _____ _____ Are you currently receiving treatment from another healthcare professional? ☐ Yes ☐ No If yes, for what? _____ _____ ☐ Surgery, date (mm/dd/yyyy): _____ Nature: _____ ☐ Injury, date (mm/dd/yyyy): _____ Nature: _____	Do you have any other medical conditions (e.g. digestive condition, 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 of any tissue or joint discomfort. _____ _____

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 condition. I understand that all massage treatments will be discussed and planned with the massage therapist, and will require my informed consent. **I understand the 24 hour cancellation policy and agree to pay the missed appointment fee if I cancel within the 24 hour period preceding my appointment time. I understand MakCare Health and Wellness Centre's lateness policy that I am responsible to pay for the time I reserved with the therapist, regardless of the time I arrive and I am ready for my appointment.**

Signature: _____ *Date:* _____

	Date (mm/dd/yyyy)	Initials
Update 1:	_____	_____
Update 2:	_____	_____
Update 3:	_____	_____
Update 4:	_____	_____

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