Stacey L. Ardiel, RMT
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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 I can ensure it is safe for you to receive treatment. Please inform me if your health status or contact information changes.

Name: _____ Date: _____

Mailing Address: _____ City: _____ Postal Code: _____

Email Address: _____
(To receive office emails, updates/notices and birthday certificates)

Date of Birth: dd_____/mm_____/yy_____

Telephone: (home) _____ (work) _____ (other) _____

Occupation: _____ What is your primary health complaint? _____

Referred by: _____ (ex. Name of friend, Google, MD etc.)

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

HEAD / NECK
- ☐ headaches
- ☐ vision problems / loss
- ☐ contact lens use
- ☐ earaches
- ☐ hearing problems
- ☐ jaw pain / TMJ disorder

RESPIRATORY
- ☐ chronic cough
- ☐ shortness of breath
- ☐ asthma – Date of last attack: _____
- ☐ bronchitis / emphysema
- ☐ Family history? ☐yes ☐no

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
- ☐ Family history?
  ☐yes ☐no

INFECTIONS
- ☐ herpes
- ☐ hepatitis
- ☐ skin condition
  Type: _____
- ☐ respiratory infection
- ☐ 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
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

Please turn over →

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Please list the timing and nature of injuries, accidents and surgeries:

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: _____

If necessary, do I have permission to send your MD 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 to treatment? ☐ Yes ☐ No

Extended health care plan? ☐ Yes ☐ No History of massage therapy? ☐ Yes ☐ No

If an appointment is missed without 24 hours notice you will be billed for the time booked.

Signature: _____

Update Health History
Update 1: _____
Update 2: _____
Update 3: _____
Update 4: _____
Update 5: _____
Update 6: _____