Health History

Welcome to Natural Path Wellness Centre. Please complete this form in full.

All information is strictly confidential. Please print.

Name: _____ Date: _____

Address: _____

City: _____ Province: _____ Postal Code _____

Phone #: (___)_____ Cell # (___)_____ Work #: (___)_____

Date of Birth: M_____D_____Y_____ Doctor: _____

Occupation: _____ Employer: _____

Emerg. contact: _____ Relationship: _____ Phone #: _____

Email: _____ How did you hear about us? _____

Do you have an insurance plan to cover you massage therapy treatments? ____ yes ____ no

Do you have an open insurance claim for a motor vehicle accident or other situation? ____ yes ___ no

Medavie Blue Cross or Green Shield clients please fill out the following:

Company ____ Medavie Blue Cross ____ Green Shield

Group/Plan # _____ ID# _____

List any past surgeries, injuries, or accidents and approximate dates:

Date _____ Injury/Surgery _____

Date _____ Injury/Surgery_____

Date _____ Injury/Surgery_____

Please list **all** medications you are **currently** taking: _____

_____

Recently discontinued medications: _____

Are you currently undergoing any other forms of treatment? __Yes __No

Please detail: _____

Do you exercise regularly? __Y __N what kind? _____

Please check off any conditions that you now have or have had:

Reproductive

- □ *Pregnant, trimester _____
- □ Ovarian/Menstrual problems
- □ Prostate
- □ Other: _____

Digestive

- □ Irritable Bowel Syndrome (IBS)
- □ Ulcers
- □ Colitis/Crohn's Disease (IBD)
- □ Other: _____

Musculoskeletal

- ☐ Bone/Joint disease
- ☐ Tendonitis
- ☐ Bursitis
- ☐ Arthritis/Gout, specify _____
- ☐ Jaw Pain/TMJ
- ☐ Spinal problems/injuries
- ☐ Other: _____

Nervous System

- ☐ Numbness Tingling
- ☐ Pinched nerve
- ☐ Shingles
- ☐ Epilepsy/Seizures
- ☐ Other: _____

Other

- ☐ Cancer/Tumors
- ☐ Bladder/Kidneys
- ☐ Diabetes, type _____
- ☐ Chronic fatigue
- ☐ Chronic pain
- ☐ Fibromyalgia
- ☐ Sleep disorders
- ☐ Migraines/headaches, type _____
- ☐ Anxiety/stress
- ☐ Depression
- ☐ Sudden loss of appetite
- ☐ Surgical Implants, specify _____

Circulatory

- ☐ Heart condition
- ☐ Phlebitis/Varicose Veins
- ☐ Blood Clots
- ☐ High/low blood pressure
- ☐ Lymphedema
- ☐ Thrombosis/Embolism

Respiratory Conditions

- ☐ Asthma
- ☐ Emphysema
- ☐ Allergies, specify: _____
- ☐ Sinus
- ☐ Other: _____

Skin

- ☐ Allergies
- ☐ Rashes
- ☐ Athletes foot
- ☐ Herpes/Cold sore
- ☐ Other: _____

Do you presently have an infectious disease?

_____Y _____ N

Additional health comments:

_____

_____

_____

_____

_____

What is your primary complaint for today's treatment? _____

_____

I have stated all conditions that I am aware of and this information is true and accurate. I will inform Natural Path Wellness Centre of any changes in my status.

Signature: _____ **Date: _____**