Magna Health CENTRE
Integrated | Compassionate | Effective Care

Health History Form

Brittany McGann, RMT

An accurate and current health history form is essential to creating safe and effective treatments that are specific to you and your needs. It is important that your health history form remains current and be regularly updated so that treatment can be adapted to any indications and contraindications to Massage Therapy treatment. All of the information collected and is recorded and kept confidential and in accordance with law. This information may only be shared discretely to facilitate assessment or treatment or as allowed or required by law.

Name: .....Date: .....

Address: .....

Telephone:…….....Email Address: .....

Date of Birth DD/MM/YYYY: .....Occupation:.....
Have you received massage therapy before? Yes / No.....
Presently or recently, involved in other health care? Yes / No.....
Were you referred for Massage Therapy by a health care practitioner? Yes/No.....
Primary care physician & Physician address: .....
…….....
What is the reason you are seeking massage therapy? Please include the area / location of any discomfort:.....
.....
.....
Are you currently receiving any other medical treatment for this issue?……
Prior Injury & Date: .....
…….
Please indicate conditions you are experiencing or have experienced below:

Cardiovascular:	Muscle / Joint:	Gastrointestinal:	Head/ Neck:
○ High Blood Pressure Low Blood Pressure ○ Chronic Congestive Heart Failure ○ Heart Attack ○ Heart Disease ○ Heart Palpations ○ Heart Murmur Stroke / CVA ○ Aneurism ○ Angina ○ Pacemaker or Similar Device ○ Blood Clots ○ Raynaud'sDisease ○ Phlebitis / Varicose Veins	○ Muscle Strain ○ Ligament sprain ○ Spasms/ cramps ○ Tendonitis ○ Bursitis ○ Fibromyalgia ○ Arthritis OA RA ○ Osteoporosis ○ Herniated disc ○ Degenerative disks ○ Scoliosis ○ Dislocation ○ Fracture	○ Constipation ○ Diarrhea ○ Gas/bloating ○ Nausea/vomiting ○ Irritable Bowel Syndrome ○ Crohn's / Colitis ○ Ulcers ○ Hernia ○ Gall Bladder problems ○ Liver problems ○ Kidney infections ○ Bladder infections ○ Urination problems ○ Poor appetite ○ Excessive thirst	○ Headaches ○ Migraines ○ Whiplash ○ Jaw pain / TMJ ○ Ear Pain ○ Tinnitus ○ Hearing loss ○ Vision problems **Blood:** ○ Anaemia ○ Haemophilia ○ Leukemia ○ Hep A B C
Lifestyle: **Regular Exercise** Yes □ No □ **Hydration** **Sleep 8 hours** Yes □ No □ Yes □ No □ **Good eating habits** Yes □ Mostly □ No □ **Health Status-feeling** Well □ Fair □ Unwell □	**Respiratory:** ○ Chronic cough ○ Shortness of breath ○ Bronchitis ○ Asthma ○ Emphysema ○ Pneumonia ○ Tuberculosis ○ Sinusitis ○ Sinus congestion	**Skin:** ○Allergies ○Hypersensitivity ○Bruise easily ○Rashes ○Eczema ○Psoriasis ○Athletes foot ○Warts	**Women:** ○ Pregnant Due_____ ○ IVF ○ Menstrual concerns/pain ○ Menopausal concerns ○ Endometriosis ○ Fibroids ○ Hysterectomy ○ Vaginal pain/infection
Other Conditions: ○ Diabetes onset:_____ ○ HIV/AIDS ○ Cancer _____	Thyroid disorders ○ Lupus ○ Loss of or altered Sensation ○ Neurological Issues	○ Fainting / Dizziness ○ Epilepsy ○ Insomnia / Fatigue ○ Multiple sclerosis	○ Anxiety / Nervousness ○ Depression ○ Addiction _____ Other_____

Current Medications: .....**Signature**_____