origin wellness
REGISTERED MASSAGE THERAPY

Health History Form

Name: _____ Date: _____
Address: _____
City: _____ Prov: _____ Postal Code: _____
Email: _____ Occupation: _____
Phone Home: _____ Work: _____ Mobile: _____
Date of Birth: _____ Preferred Pronoun: _____
Weight: _____ Height: _____

Sports/Hobbies/Exercise
Type: _____ Frequency: _____

In general, my health is: _____

Where did you hear about the clinic?
_____

Can we add you to our mailing list to receive occasional email newsletters?
O yes O no

What brings you in for a massage?
_____
_____

Do you have insurance coverage for massage therapy?
☐ extended health benefit

Health History: Please check the conditions that you are currently experiencing, or have experienced in the past.

Head/Neck
current previous
☐ ☐ headaches
type: _____
frequency: _____
☐ ☐ vision problems
☐ ☐ hearing loss
☐ ☐ earaches
☐ ☐ other: _____

Respiratory
current previous
☐ ☐ chronic cough
☐ ☐ pneumonia
☐ ☐ shortness of breath
☐ ☐ smoking
☐ ☐ breathing disorders
(i.e. asthma, bronchitis, emphysema)
type: _____
☐ ☐ sinus problems
☐ ☐ other: _____

Skin
current previous
☐ ☐ skin conditions
type: _____
☐ ☐ loss or change of sensation
☐ ☐ bruise easily
☐ ☐ plantar warts
☐ ☐ other: _____

Women
current previous
☐ ☐ menstrual problems o painful
☐ ☐ gynaecological surgery
type: _____
☐ ☐ pregnant
due date: _____
children # _____
☐ ☐ menopausal problems
☐ ☐ other: _____

Infections
current previous
☐ ☐ hepatitis
☐ ☐ tuberculosis
☐ ☐ HIV / AIDS
☐ ☐ other: _____

Other Conditions
current previous
☐ ☐ difficult digestion
☐ ☐ constipation
☐ ☐ crohn's disease or colitis
☐ ☐ ulcers
type: _____
☐ ☐ diabetes
onset: _____
insulin: _____
☐ ☐ gallbladder
☐ ☐ kidney
☐ ☐ bladder
☐ ☐ liver
☐ ☐ cancer
type: _____
where: _____
☐ ☐ epilepsy
☐ ☐ multiple sclerosis
☐ ☐ parkinson's disease
☐ ☐ osteoporosis
☐ ☐ fibromyalgia
☐ ☐ chronic fatigue syndrome
☐ ☐ polio
☐ ☐ artificial joints/limbs/pins/wires
☐ ☐ use wheelchair/walker/cane etc
☐ ☐ other: _____
_____

Allergies (food, nuts, oils, scents, hay fever, etc.)
_____

Sleeping Issues? Please describe
_____

Cardiovascular
current previous
☐ ☐ high blood pressure
☐ ☐ low blood pressure
☐ ☐ poor circulation
☐ ☐ heart disease/heart attack
☐ ☐ pacemaker
☐ ☐ chronic congestive heart failure
☐ ☐ phlebitis
☐ ☐ stroke
paralysis? _____
☐ ☐ varicose veins
doctor diagnosed? O yes O no
☐ ☐ other: _____

Medical Doctor
name: _____
phone: _____
address: _____
date of last visit: _____

Other Healthcare
current previous
☐ ☐ massage
frequency: _____
most recent: _____
☐ ☐ chiropractic
☐ ☐ physiotherapy
☐ ☐ exercise
☐ ☐ nutritionist
☐ ☐ naturopath
☐ ☐ homeopath
☐ ☐ osteopath
☐ ☐ psychiatrist/other talk therapist
☐ ☐ neurologist

Please see reverse for additional information

Musculoskeletal

current previous — where / when

- ☐ ☐ joint sprain _____
- ☐ ☐ muscle strain _____
- ☐ ☐ fracture _____
- ☐ ☐ dislocation _____
- ☐ ☐ whiplash _____
- ☐ ☐ low back pain _____
- ☐ ☐ scoliosis _____
- ☐ ☐ bursitis _____
- ☐ ☐ tendinitis _____
- ☐ ☐ carpal tunnel syndrome _____
- ☐ ☐ frozen shoulder _____
- ☐ ☐ flat feet _____
- ☐ ☐ sciatica _____
- ☐ ☐ arthritis
  - ○ osteo- or ○ rheumatoid?
  - where: _____
  - family history? _____
  - doctor diagnosed? ○ yes ○ no
- ☐ ☐ other: _____

Pain/Stiffness

current previous

- ☐ ☐ jaw
- ☐ ☐ neck
- ☐ ☐ shoulder ☐ L ☐ R
- ☐ ☐ upper back
- ☐ ☐ mid-back
- ☐ ☐ lower back
- ☐ ☐ elbow ☐ L ☐ R
- ☐ ☐ wrist ☐ L ☐ R
- ☐ ☐ hip ☐ L ☐ R
- ☐ ☐ thigh ☐ L ☐ R
- ☐ ☐ knee ☐ L ☐ R
- ☐ ☐ leg ☐ L ☐ R
- ☐ ☐ ankle ☐ L ☐ R

Do you take any medication?

Name of Medication — Condition It Treats

_____

_____

_____

_____

Injury & Surgery

e.g. motor vehicle accidents, falls, work- & sport-related injuries

Please include all injuries and surgeries, even those you may feel are not relevant.

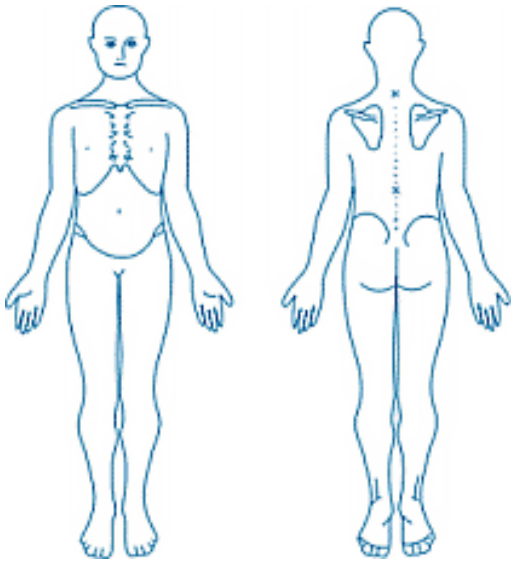
type: _____ date: _____
current symptoms: _____
_____

type: _____ date: _____
current symptoms: _____
_____

type: _____ date: _____
current symptoms: _____
_____

type: _____ date: _____
current symptoms: _____
_____
_____
_____

On the diagrams below, please indicate with an 'x' any areas of pain or discomfort you are experiencing.



Acknowledgement of Privacy & Information Policy

I understand that the information that I give on this form will be confidential and will be used for no other purpose than the professional therapist's records. If another Health Care professional referred me for Massage Therapy, I hereby authorize my Registered Massage Therapist to discuss information regarding my records with that Health Care Professional.

signature: _____ date: _____

signature: _____ date: _____

Consent to Cancellation/Late Policy

Origin Wellness enforces a 24-hour cancellation policy, where we reserve the right to charge you for your missed or cancelled appointment if not enough notice is provided. The fee charged is the total cost of your treatment time. If you are unable to make your scheduled time, let us know ASAP by phone, to avoid being charged. Cancellations can not be done online, but you will be able to reschedule an appointment up to 48hrs before your currently scheduled appointment. Thanks for your consideration.

For patients arriving late for their appointment, we will only be able to provide treatment for the remaining time in your session. However, full booked treatment fees will apply.

signature: _____ date: _____

signature: _____ date: _____