ISM REHAB
INNOVATION SCIENCE & MEDICINE

Health History

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 confidential unless allowed of required by law. Your written permission will be required to release any information.

Name:		Date of Birth (YYYY/MM/DD): / /
Address:		
City:	Province:	Postal Code:
Home Phone:		Other Phone:
Email:		Preferred method of Contact:
Occupation:		
Have you received massage therapy before? ☐ Yes ☐ No		
Did a health care practitioner refer you to massage therapy? ☐ Yes ☐ No		
If yes, provide their name and phone number:		
Family physician name and phone number:		
Have you received treatment from another health care professional in the past year? ☐ Yes ☐ No		
If yes, please provide type of treatment (chiropractic, physiotherapy etc.):		
Emergency Contact:		Phone:
Primary reason for massage therapy:		
Injuries:		Date of Occurrence:
Were these injuries sustained as a result of a motor vehicle accident? ☐ Yes ☐ No		
Were these injuries sustained as a result of a workplace injury? ☐ Yes ☐ No		
Please list all surgeries/Medication(s):		
Insurance Company: _____ Policy Holder: _____ Policy: ID/Certificate:		

ISM Rehab
Massage Intake Form

Please indicate any conditions you are experiencing or have experienced:

Cardiovascular
- ☐ High blood pressure
- ☐ Low blood pressure
- ☐ Chronic Congestive heart failure
- ☐ Heart Attack
- ☐ Heart Disease
- ☐ Heart palpations
- ☐ Heart Murmur
- ☐ Stroke/CVA
- ☐ Aneurism
- ☐ Blood Clots
- ☐ Raynaud's Disease
- ☐ Phlebitis/ Varicose Veins
- ☐ Poor Circulation
- ☐ Pacemaker or Similar device

Respiratory
- ☐ Chronic Cough
- ☐ Shortness of Breath
- ☐ Bronchitis
- ☐ Asthma
- ☐ Pneumonia
- ☐ Tuberculosis
- ☐ Sinusitis
- ☐ Sinus Congestion

Do you smoke? Yes__ No__

Blood
- ☐ Anaemia
- ☐ Haemophilia
- ☐ Leukemia
- ☐ Hepatitis: A__ B__ C__

Lifestyle: Rate 1-5. (5 is high)

Regular exercise: ____
Drink plenty of water____
8 Hours of sleep ____
Good eating habits ____

Any internal pins, wires, artificial joints, or equipment? _____

Gastrointestinal
- ☐ Constipation
- ☐ Diarrhea
- ☐ Gas/ Bloating
- ☐ Nausea/ Vomiting
- ☐ Irritable Bowel Syndrome
- ☐ Crohn's/ Colitis
- ☐ Hernia
- ☐ Ulcers
- ☐ Gall Bladder Problems
- ☐ Liver Problems
- ☐ Urination Problems
- ☐ Poor Appetite
- ☐ Excessive Thirst

Skin
- ☐ Allergies: _____
- ☐ Hypersensitivity
- ☐ Bruise easily
- ☐ Rashes: _____
- ☐ Eczema
- ☐ Psoriasis
- ☐ Athletes Foot
- ☐ Herpes
- ☐ Warts
- ☐ Skin Conditions: _____

Women
- ☐ Pregnant, Due: _____
- ☐ Infertility
- ☐ Menstrual Concerns/ Pain
- ☐ Menopausal Concerns
- ☐ Endometriosis
- ☐ Fibroids
- ☐ Hysterectomy
- ☐ Vaginal Pain/ Infection

General health

Good___ fair ___ Poor ___

Other (Please List) :

Head/ Neck
- ☐ Headaches
- ☐ Migraines
- ☐ Whiplash
- ☐ Jaw Pain
- ☐ Ear Pain/Infection
- ☐ Hearing Problems
- ☐ Hearing Loss
- ☐ Vision Loss/ Problems

Muscle/ Joint
- ☐ Muscle Strain
- ☐ Ligament Sprain
- ☐ Spasms/ Cramps
- ☐ Tendinitis
- ☐ Bursitis
- ☐ Fibromyalgia
- ☐ Ankylosing Spondylitis
- ☐ Arthritis: OA___ RA____
- ☐ Osteoporosis
- ☐ Herniated Disc
- ☐ Degenerative Discs
- ☐ Joint or Bone Disease
- ☐ Scoliosis
- ☐ Dislocation
- ☐ Fracture

Other Conditions
- ☐ Diabetes, Onset: _____
- ☐ HIV/ AIDS
- ☐ Cancer: _____
- ☐ Multiple Sclerosis
- ☐ Epilepsy
- ☐ Thyroid Disorders
- ☐ Lupus
- ☐ Loss of Sensation: _____
- ☐ Insomnia/ Fatigue
- ☐ Fainting / Dizziness
- ☐ Depression
- ☐ Alcohol/ Drug Addiction