Ken Shim, RMT – Health History Form

An accurate health history is important to ensure that it is safe for you to receive a massage treatment. If your health status changes in the future, please inform your therapist. All information gathered for this treatment is confidential except as required or allowed by law or except to facilitate diagnosis (assessment) or treatment. You will be asked to provide written authorization for release of any information.

PERSONAL INFORMATION

Name:_____ Today's Date _____

Phone (Home) _____(cell)_____ Date of Birth _____

(Work) _____ Primary Complaint _____

Address _____ Occupation _____

City _____ Postal Code_____ Physician & Address _____

Email _____ Who referred you? _____

HEALTH HISTORY

Please indicate all current and past conditions you have experienced.

Head/Neck	Current	Past
Whiplash	☐	☐
Headache	☐	☐
Migraine	☐	☐
Concussion	☐	☐
Ringing in the ears	☐	☐
Hearing loss	☐	☐
Vision problems	☐	☐
Brain injury	☐	☐
TMJ (Jaw Pain)	☐	☐
Other:		

Respiratory/Lungs	Current	Past
Asthma	☐	☐
Bronchitis	☐	☐
Emphysema	☐	☐
Shortness of breath	☐	☐
Chronic cough	☐	☐
Other:	☐	☐

Is there a family history of any of the above?

Digestive	Current	Past
Constipation	☐	☐
Diarrhea	☐	☐
Crohn's Disease	☐	☐
Irritable Bowel Syndrome	☐	☐
Ulcers	☐	☐
Diverticulitis	☐	☐
Nausea	☐	☐

Other:

Cardiovascular	Current	Past
High blood pressure ____/____	☐	☐
Low blood pressure ____/____	☐	☐
Heart attack	☐	☐
Chronic congestive heart failure	☐	☐
Stroke/CVA	☐	☐
Pacemaker or similar device	☐	☐
Phlebitis/Varicose veins	☐	☐
Heart Disease	☐	☐
Other:		

Is there a family history of any of the above?

Nervous System	Current	Past
Spinal cord injury	☐	☐
Seizures/Epilepsy	☐	☐
Numbness/Tingling	☐	☐

Where?

Other:

Artificial Joints, plates, pins	☐	☐

Infections	Current	Past
Hepatitis	☐	☐
Type:		
Infectious skin conditions	☐	☐
Type?		
TB	☐	☐
HIV	☐	☐
Herpes	☐	☐

Other:

Disease/condition	Current	Past
Cancer _____	☐	☐
Diabetes _____	☐	☐
Treatment:	☐	☐
Fibromyalgia	☐	☐
Chronic Fatigue Syndrome	☐	☐
Allergies _____	☐	☐
Other		

WomenOnly	Current	Past
Pregnancy	☐	☐
Vaginal Birth/abortion		☐

Due Date:

Current gynaecological conditions:

Bone/Joint	Current	Past
Dislocation/Fracture	☐	☐
Osteoarthritis	☐	☐
Rheumatoid Arthritis	☐	☐
Degenerative disc disease	☐	☐
Herniated disc	☐	☐
Other:		

Accidents/Injuries/Operations	Year	Accidents/Injuries/Operations	Year

Current medications and the conditions they treat: _____

For your current condition, have you tried any of the following (Use an '**X**' if it was unsuccessful or a '√' if it was successful):
☐ Massage ☐ Chiropractic ☐ Physiotherapy ☐ Acupuncture ☐ Osteopath ☐ Yoga ☐ Pilates ☐ Stretching & Exercise

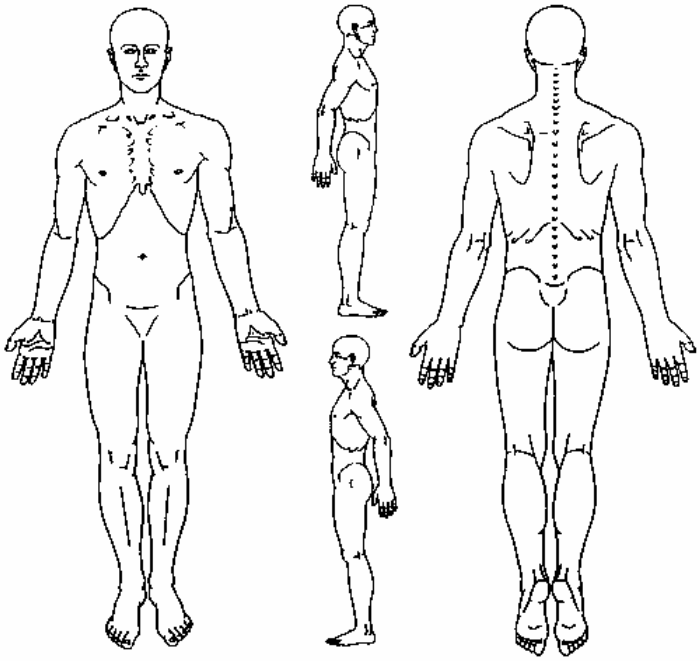
Are you physically active? Yes ☐ No ☐
How often? _____
Type of exercise: _____

Previous massage experience: Yes ☐ No ☐
Good sleeping habits: Yes ☐ No ☐
Regular eating habits: Yes ☐ No ☐

Current Symptoms:

1. On the diagram, use the following letters to indicate the locations of your pain:
A - Ache/Dull pain P - Pins & Needles/Tingling
B – Burning N - Numbness

2. Beside each letter, mark the intensity of pain with a number from 1 to 10 (i.e. 0 - no pain, 10 - child birth)



What is your general level of pain **now** (0 – 10)? _____

What is the level of your pain at its worst (0-10)? _____

How often do you feel the pain? _____

When did the pain start? _____

What caused it? _____

What movements or activities make the pain worse? _____

What relieves the pain? _____

What has the pain stopped you from doing? _____

What goals do you want massage therapy to accomplish for you? _____

List any areas that you do not want treated: _____

Date _____ Date _____

Client's Signature _____ Therapist's Signature _____

Update 1 _____
Update 2 _____
Update 3 _____
Update 4 _____