Massage Therapy Niagara

The following confidential health questionnaire, as well as the subsequent verbal intake questions, are necessary to assess your situation and to create a proper and accurate treatment protocol. Physical, mental and emotional well being and history all play a role. If anything is unclear, or you aren't comfortable answering certain private questions, please let me know and we will do our best accordingly.

We are here to help.

Osteopathic Health History Questionnaire

Patient Name: _____Telephone Number:_____

Date of Birth: _____ Email address: _____

Home address: _____

Family physician name & address:_____

General Information

Occupation and description job related activities:_____

Are you currently seeing a: Physician / Chiropractor / Physiotherapist / Massage therapist / Other:_____

Date of last consultation with any of the above practitioners: _____

Do you wear orthodics or a prosthesis? Yes / No _____

Have you had any medical imaging tests? X-rays / MRIs / Scans / Blood tests / Other:_____

What were the results:_____

Please describe your sleeping habits:_____

Please describe your eating habits/diet:_____

Please describe your exercise/activities/sports:_____

Past Medical History

___ osteoporosis	___ heart disease	___ eczema / hives	___asthma
___ osteoarthritis	___ ulcers	___ liver disease	___ depression
___ rheumatoid arthritis	___ urinary infection	___ thyroid disease	___ pneumonia
___ gout	___ immune disorders	___ anemia	___ gall / kidney stones
___ high cholesterol	___ insomnia	___ bleeding disorder	___ Anxiety / nerves
___ high blood pressure	___ blood clots	___ diabetes	___ Pregnacy
___ headaches/migraine	___ glaucoma	___ stroke / aneurism	___ Menopause
	___ hepatitis	___ seizures	Other please specify:

Past Surgical History

__tonsils	__ovaries	__abdomen	__bunions
__adenoids	__eye	__gallbladder	__fractures
__appendix	__neck	__bowel	__stitches
__uterus	__chest	__breast	Other please specify:
__tooth extraction	__skin excision	__circumcision	

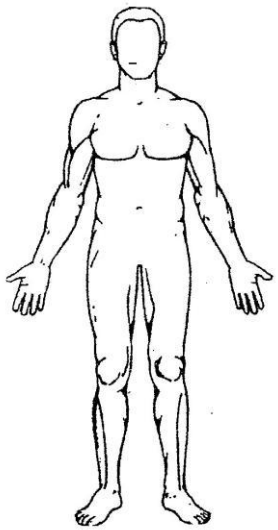
Check off any of the following symptoms you have experienced in the past 6 months

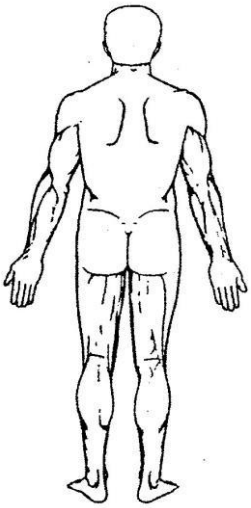
___ Headaches / Migraine	___ Hip Pain	___Tension Across Top of Shoulders
___ Pain Between Shoulder Blades	___ Numbness / Tingling in Arms / Hands	___ Carpal Tunnel Syndrome
___ Knee Pain	___ Numbness / Tingling in Legs / Feet	___ Low Back Pain / Sciatica
___ Ankle / Foot Pain	___ Loss of Grip Strength	___ Neck Pain
___ Wrist / Hand Pain	___ Work Related Injury	___ Burning in Arms / Legs
___ Elbow / Shoulder Pain	___ Automobile Accident Injury	___ Cold Feeling in Arms / Legs

Do you experience:

___ Fatigue	___ Anxiety
___ Difficulty Sleeping	___ Painful / Frequent Urination
___ Ringing in Ears	___ Heartburn
___ Nervousness	___ Reflux
___ Dizziness	___ Constipation
___ Digestive Disturbances	___ Diarrhea
___ Depression	___ Other:

Mark lines (////) where you have numbness/tingling. **Mark circles (oooo) where you have pain.**





What is your main reason for seeking osteopathic treatment?_____

When do you feel the pain/problem **the most?**_____

When do you feel the pain/problem **the least**?_____

What treatments have you sought for this problem/pain?_____

Any earlier related or unrelated injuries or trauma?_____

Cancellation Policy & Consent to Treatment

By completing and signing this health history questionnaire and by attending the above mentioned appointment, you agree to Osteopathic treatment (for your child) and agree to provide minimum 24 hrs notice should you need to re-schedule your appointment. **Missed appointments without adequate prior notice will be charged the full amount of the consultation.**

Guardian / Patient signature: _____ **Date**:_____