

Priority Massage and Health
172 Wortley Road
London, Ontario
N6C 3P7
Health History Form – page 1

An accurate health history is important to ensure that it is safe for you to receive treatment. All information gathered is confidential except as required or allowed by law. At times when multiple therapists are treating the same patient, files and information will be shared to allow the best delivery of health care. Written authorization will be required for release of any information.

Name: _____ Sex: F ____ M ____
 Telephone Res: _____ Bus: _____
 Address: _____ City _____ Postal Code _____
 Date of Birth: _____ Occupation: _____ Hobbies: _____
 Email: _____
 Is this your first time receiving this type of therapy (i.e. chiropractic, massage, physiotherapy, athletic therapy, nutrition counseling)? YES / NO
 Reason for treatment today: _____

Please indicate conditions you are experiencing or have experienced in the past, using a ✓, or fill in box appropriately.

Soft Tissue/Joints	Respiratory	Skin	Genitourinary
Neck	Chronic cough	Skin condition/specify:	Prostate
Shoulder	Shortness of breath	Bruise easily	UTI
Upper back	Bronchitis	Herpes	Painful urination
Low back	Asthma	Varicose veins	
Arms	Emphysema	Athletes foot	Women's Health
Legs	Pneumonia	Loss of sensation	Painful menstruation
Knees	Sinus problems	Other	Irregular menstruation
Hip	Other		Currently on birth
Other		Other conditions	control pill Y / N
	Cardiovascular	Neurological	Number of pregnancies
Headaches	High blood pressure	Epilepsy	Number of children
Tension	Low blood pressure	Diabetes Type:	Reg. breast exams Y / N
Migraine	Heart disease	Allergies	Reg. pelvic exams Y / N
Tooth/jaw/ear pain	Phlebitis	Cancer	
Head trauma/date:	Stroke/CVA	Arthritis	
Other	Heart attack	Type: OA /RA / other	
	Pacemaker	Where?	
Accidents/Injuries	Angina	Vision problems	
Car accident/date:	Congestive heart failure	Hearing conditions	
Work related/date:	Other	Digestive problems	
Symptoms:		Sleep disturbance	
Physical Limitations:	Infectious disease	Hemophilia	
	Hepatitis	Depression	
	HIV	Other	
	Tuberculosis		
	Other		

Primary Practitioner: Dr. Jerry Singh D.C

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Health History Form – page 2

Name: _____

Name of Primary Physician _____ Phone number _____

Previous Surgery: Y / N Type/Date _____

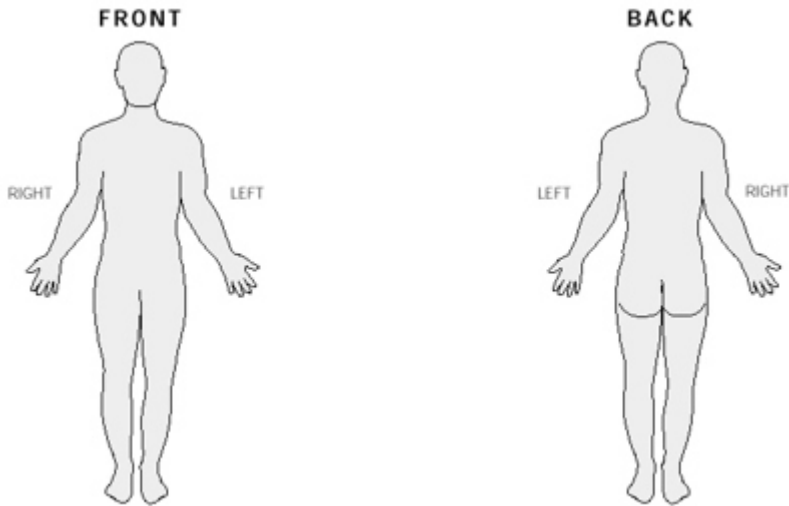
Current medications/supplements _____

Allergies _____

Present use of other health care: Y / N Please specify _____

Current symptoms _____

Please use this space to elaborate on any of the above or other conditions, if needed.



Use this diagram to show where you have your pain. Mark the area with the symbol that best describes your pain:

- Aching Pain *****
- Burning Pain xxxxxxxx
- Numbness =====
- Pins and needles OOOOO
- Stabbing pain /////