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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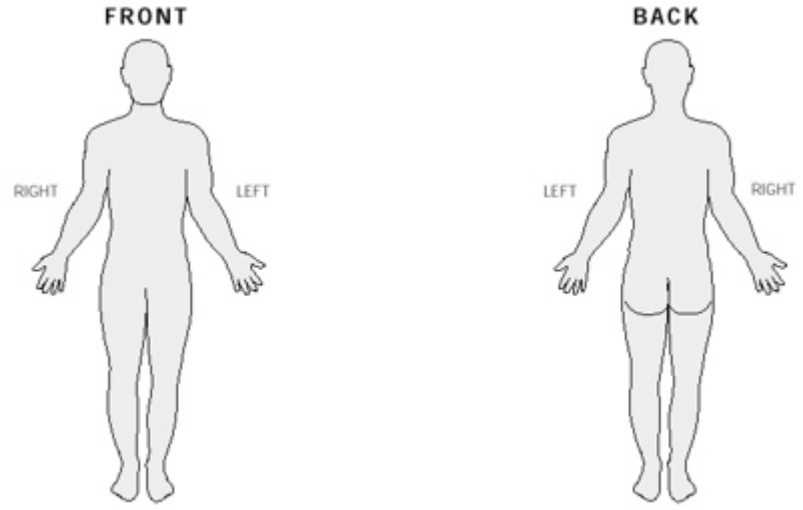
Health History Form – page 2

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	/ / / / / /

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