

# Cassy Grant

DAWKINS CHIROPRACTIC CLINIC  
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## Health History Form

For Your Information:

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 let me know. 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: \_\_\_\_\_  
Address: \_\_\_\_\_ Date of Birth: \_\_\_\_\_  
City: \_\_\_\_\_ Postal Code: \_\_\_\_\_ Occupation: \_\_\_\_\_  
Phone Number: \_\_\_\_\_ Work Number: \_\_\_\_\_  
Primary Care Physician: \_\_\_\_\_ Phone Number: \_\_\_\_\_  
Who Referred You? \_\_\_\_\_ Recreational activities: \_\_\_\_\_  
What is your Primary Complaint? \_\_\_\_\_  
How long have you had this condition? \_\_\_\_\_  
What aggravates/ relieves this condition? \_\_\_\_\_  
What are your goals for this massage treatment? \_\_\_\_\_

Other Health Care:  Chiropractic:  Physiotherapy:  Other: \_\_\_\_\_  
Overall Health:  Good  Fair  Poor  
Exercise:  Competitive  Recreational  Rehabilitative  
Dominant Hand:  Left  Right  
Previous Massage Experience:  Yes  No  
Good Sleeping Habits:  Yes  No  
Regular Eating Habits:  Yes  No

Current medications and conditions it treats: \_\_\_\_\_

Surgical operations (Include date): \_\_\_\_\_

Major injuries/accidents (Include date): \_\_\_\_\_

Of special note (pins, wires, plates, artificial joints, special equipment and location): \_\_\_\_\_

### Health History

Please indicate all current and past conditions you have experienced.

#### Head/Neck

- Whiplash
- Headache
- Migraine
- Concussion
- Ringing in the ears
- Hearing Impairment
- Vision Impairment
- Speech Impairment
- TMJ (Jaw Pain)
- Brain Injury
- Other: \_\_\_\_\_

#### Respiratory

- Asthma
- Bronchitis
- Emphysema
- Pneumonia
- Shortness of Breath
- Sinusitis
- Frequent Colds
- Recurrent Lung Infection
- Chronic Cough
- Dizziness
- Smoking
- Other: \_\_\_\_\_

#### Cardiovascular

- High Blood pressure: \_\_\_/\_\_\_
- Low Blood Pressure: \_\_\_/\_\_\_
- Heart Attack
- Chronic Congestive Heart Failure
- Chest Pain/Angina
- Stroke
- Pace Maker or Similar Device
- Phlebitis
- Hemophilia
- Poor Circulation/Varicose Veins
- heart Disease
- Other: \_\_\_\_\_

**Digestive**

- Constipation
- Diarrhea
- Crohn's
- Irritable Bowel Syndrome
- Nausea
- Frequent Urination
- Poor Appetite
- Excessive Appetite
- Hiatus Hernia
- Ulcers
- Diverticula
- Other: \_\_\_\_\_

**Nervous System**

- Spinal Cord Injury
- Numbness
- Sensory (Change/Loss)
- Sciatica
- Thoracic Outlet Syndrome
- Tingling
- Seizures
- Multiple Sclerosis
- Cerebral Palsy
- Epilepsy
- Carpal Tunnel Syndrome
- Other: \_\_\_\_\_

**Disease/Condition**

- Fibromyalgia
- Chronic Fatigue Syndrome
- Allergies: \_\_\_\_\_
- Cancer: (Benign/Malignant)  
Treatment: \_\_\_\_\_
- Diabetes: (Type) \_\_\_\_\_  
Onset: \_\_\_\_\_
- Liver
- Kidney
- Gallbladder
- Bladder
- Other: \_\_\_\_\_

**Skin**

- Frostbite
- Sensitive Skin
- Rash/Eruptions
- Contagious Condition
- Cold Sores
- Bruise Easily
- Other: \_\_\_\_\_

**Infections**

- Hepatitis: (Type) \_\_\_\_\_
- Tuberculosis
- HIV/AIDS
- Skin Conditions
- Herpes
- Influenza
- Plantar Warts
- Other: \_\_\_\_\_

**Muscle/Soft Tissue**

- Pain
- Strain
- Stiffness
- Restricted Movement
- Tendonitis
- Poor Posture
- Weakness
- Spasm
- Other: \_\_\_\_\_

**Bone/Joint**

- Pain
- Sprain
- Swelling
- Limited Movement
- Dislocation
- Fracture
- Arthritis: (OA/RA)
- Degenerative Disc Disease
- Prolapsed/herniated Disc
- Osteoporosis
- Bursitis
- Other: \_\_\_\_\_

**Soft Tissue/Joint discomfort**

- Neck
- Shoulder
- Arm
- Wrist/Hand
- Upper Back
- Mid Back
- Low Back
- Hips
- Legs
- Knees
- Feet
- Other: \_\_\_\_\_

**Women Only**

- Pregnancy  
Due Date: \_\_\_\_\_
- Vaginal Birth
- Gynecological  
Conditions: \_\_\_\_\_
- Number of Children: \_\_\_\_\_
- Other: \_\_\_\_\_

**CONSENT TO TREATMENT**

I hereby consent to the massage therapy treatment as described by my therapist. I understand and agree to the techniques that will be used, their desired effects and possible side effects, and the anticipated duration of the treatment. I understand that I have the right to ask questions about my treatment and to stop, or alter my treatment, and also to clarify the reason for particular techniques being used in my treatment. I agree to take responsibility for my health and lifestyle choices.

**Date:** \_\_\_\_\_ **Signature:** \_\_\_\_\_