Good Health
Wellness Center

Health History Form

The information request below will assist us in treating you safely. Feel free to ask any questions about the information being requested. Please note that all information provided below will be kept confidentially unless allowed or required by law. Your written permission will be required to release any information.

Name: _____ Tel: _____

Occupation: _____ Date of Birth: _____

Have you received massage/ Physio/ Chiro/ Acupuncture/ Naturopath therapy before? YES / NO

Did a Healthcare practitioner refer you for any of the above therapy? YES / NO

Name of Dr: _____ Tel: _____

Please indicate (X) conditions you are experiencing or have experienced:

Cardiovascular: *high blood pressure *low blood pressure *heart-attack *stroke *pacemaker Is there family history of any of the above: **YES / NO**	**Infections:** *hepatitis *skin conditions *TB * HIV * Herpes Is there family history of any of the above: **YES / NO**	**Head & Neck:** *history of headaches *history of migraines * vision problem *vision loss *hearing loss Is there family history of any of the above: **YES / NO**
Respiratory: *chronic cough *shortness of breath * bronchitis *asthma * emphysema Is there family history of any of the above: **YES / NO**	**Women:** *pregnant *any gynaecological conditions (----------) Do you have any internal pins, wires, artificial joints or equipment? **YES/NO** Do you have any other medical conditions we should be aware of?	**Other Conditions:** *loss of sensations * diabetes *cancer *epilepsy *arthritis * varicose veins * transplants Is there family history of any of the above: **YES / NO**

Current Medications: _____

_____

Are you currently receiving treatment from another health care professional? **YES / NO**

Signature:_____ **Date:**_____

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