Horseshoe Wellness
CHIROPRACTIC & ACUPUNCTURE

Massage Therapy Health History

*Date*_____

*Name*_____ *Home Phone:*_____

*Address*_____ *Postal Code*_____ *Cell Phone:*_____

*Email*_____ *Would you like email appointment reminders?*_____

*Date of Birth(mm/dd/yy)*_____ *Occupation*_____ *Marital Status M S CL D W*

*Physician's Name*_____ *City*_____ *Phone Number*_____

*Children (ages if under 18)*_____ *Recreational Activities/Hobbies*_____

*How did you hear about Horseshoe Wellness?*_____

*What brings you in for Massage Therapy?*_____

Health History (circle past issues and check current issues)

Head
___ Blurred Vision
___Glasses/Lenses
___Dizziness
___Frequent Colds
___Ear aches

Nervous System
___Epilepsy
___Twitching/Shaking
___Travelling leg/arm pain
___Nerve Impingement
___Nerve Damage

Digestive System
___Irritable Bowl
___Constipation
___Liver/Gallbladder
___Kidney/Bladder

Respiratory System
___Chronic cough
___Shortness of Breath
___Smoking: Heavy/Light
___Asthma
___Emphysema

Cardiovascular
___High Blood Pressure
___Low Blood Pressure
___Heart Disease
___Poor Circulation
___Phlebitis
___Varicose Veins
___Thrombus

Skin
___Sensitive Skin
___Cold Sores
___Herpes
___Bruise easily

Reproductive System
___Menstrual Problems
___Pregnant:
Due Date_____
Complications?_____
___Prostate problems
___Testicular pain
___Fertility Problems

Other Conditions
___Insomnia
___Diabetes:
___Scoliosis
___Epilepsy
___Cancer: where_____
___Arthritis: type_____
Dr. Diag?_____ Areas___

Current Medication:_____
Current treatment by other health care practitioners (ie. Chiro, Physio, Acupuncture):_____

Horseshoe Wellness Chiropractic & Acupuncture – Dr. Julie Callan –
37 Landscape Dr. Oro Medonte ON L0L2L0
705-220-4996

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Previous Surgeries/Injuries_____ Yr _____Residual Symptoms_____
If injury was serious please provide details_____
Do you have any of the following (please circle): Pins, Wires, Plates. Where are they located?_____
Do you use any of the following? (Please circle): Walkers, Cane, Wheel Chairs, Artificial Limbs

Do you:
Eat Regularly_____ Exercise Regularly_____ How often?
Avg hours of sleep?_____ Approx. Water consumption daily?(glasses or mL)_____

Headaches
Frequency_____ Tension or Migraine_____ if Migraine, Dr. Diagnosed?_____
Medication:_____ How often?_____ When did you last take a dose(if today)?_____
Where do you most commonly feel your headache:
___Whole right head ___Whole left head ___Tight band around your head ___Base of head
___Temples ___Top of head at back ___Behind eyes ___Across Forehead ___Sinus'

Muscles and Joints

___Neck	R/L	pain/stiffness/limited movement/ disc degeneration
___Shoulder	R/L	pain/stiffness/limited movement
___Shoulder joint	R/L	pain/stiffness/limited movement
___Between shoulder blades	R/L	pain/stiffness/troubles with deep breath
___Mid Back	R/L	pain/stiffness/limited movement/curvature
___Low Back (above hips)	R/L	pain/stiffness/limited movement/curvature/disc degeneration
___Low Back (below hips)	R/C/L	pain/stiffness/limited movement
___Elbow	R/L	pain/stiffness/limited movement
___Wrist/Hand	R/L	pain/stiffness/limited movement/previous sprain/break
___Upper leg	R/L	pain/stiffness/limited movement
___Knee	R/L	pain/stiffness/limited movement
___Shin	R/L	pain/stiffness
___Ankle	R/L	pain/stiffness/limited movement/previous sprain/break
___Foot	R/L	pain/stiffness/limited movement/plantar fasciitis

Is any of the pain preventing you from functioning normally on a daily basis? If yes, please explain._____
_____

I, hereby, declare that the above health history was filled out by _____ on the _____day of _____, 20__.

_____
Signature of Client or Parent/Guardian

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