131 Union Street East,
Suite #103
Waterloo, ON
N2J 1B8

The Natural Way
HEALTH CLINIC
where healing begins

(T) 519-772-2116
(F) 886-731-5603
www.thenaturalwayclinic.com

The Natural Way Clinic – Health History Form – Massage Therapy

Name: _____ Date of Birth: _____
Address: _____ Referred by: _____
City: _____ Home Phone# _____
Postal Code _____ Work Phone# _____
Email: _____ Cell Phone # _____
Occupation: _____
Primary Health Care Professional _____
Emergency Contact _____ Phone_____
☐ **I give my consent to include my e-mail address on the clinic newsletter mailing list**

*** Please check all current and past conditions**

MUSCLE / JOINTS / NERVES
- ☐ Headaches
  Type _____
  Frequency _____
- ☐ Arthritis
  Type _____
- ☐Tendonitis/ Bursitis
  Location _____
- ☐ Altered sensation
  Location _____
- ☐ Fractures
  Location _____
- ☐ Degenerated discs
- ☐ Strains/ sprains
  Location _____
- ☐Scoliosis
- ☐ Sciatica
- ☐ Carpel tunnel syndrome
- ☐ Whiplash
  Date _____
- ☐ Muscle or nerve disease
- ☐ Epilepsy
- ☐ Multiple sclerosis
- ☐ Cerebral palsy
- ☐ Parkinson's

CIRCULATORY/ RESPIRATORY
- ☐ High blood pressure
- ☐ Low blood pressure
- ☐ Chronic Congestive Heart failure
- ☐ Heart disease
- ☐ Heart attack
  Date _____
- ☐ Stroke
  Date _____
- ☐ Chest pain/ Angina
- ☐Varicose veins/phlebitis
- ☐ Hemophilia
- ☐ Deep vein thrombosis
- ☐ Raynaud's disease/phenomenon
- ☐ Buerger's disease
- ☐ Chronic cough
- ☐ Asthma / Bronchitis
- ☐ Emphysema
- ☐ Shortness of breath
- ☐ Swelling
- ☐Light headed/ fatigue
- ☐Bruise easily
- ☐Dizziness
- ☐ Sinus problems

GENERAL
- ☐ Do you smoke: YES or NO
- ☐Allergies _____
  _____
- ☐Diabetes
- ☐ Cancer _____
  _____
- ☐ Undiagnosed lump
- ☐Osteoporosis
- ☐ Pins, wires, artificial joints, pacemaker, hearing aid _____
- ☐ Kidney problems
- ☐Liver problems
- ☐ Inflammatory bowel disease (Crohn's, colitis)
- ☐Irritable bowel
- ☐Nausea
- ☐ Constipation
- ☐ Diarrhea
- ☐ Ulcer
- ☐ Hearing &/vision loss
- ☐ Contagious conditions
  _____
- ☐ Infectious skin conditions
  _____
- ☐ Sensitivities (i.e. oils….)
  _____

Other Conditions please elaborate: _____
_____
_____

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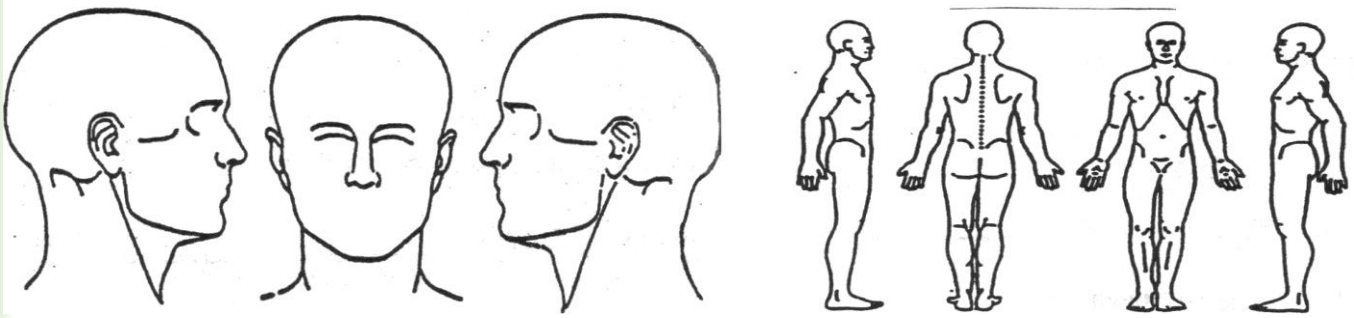
Have you received massage therapy before? Y __ N___ When was your last treatment?_____
What is your primary reason for receiving massage therapy today? (Including goals, expectations for today and the long term) _____
How did this condition begin? _____
*Please mark areas of pain, tension, swelling, decreased movement etc. on diagrams:



Please list any medications and supplements that you are taking and what they are for: _____
_____
_____

Please list any injuries or accidents you have experienced, the date/year they occurred and the treatments you received for them at the time: _____
_____
Have you been hospitalized? Y ___ N ___Please list dates and reasons: _____
_____
_____

Women
Are you pregnant? Y__ N___ Due Date _____ Menstrual Problems? _____
Number of previous pregnancies _____ and Pregnancies to term _____

I, _____declare that all of the above information is correct, and if it should change, it is my responsibility to notify the therapist of these changes at the next scheduled appointment. I understand that all information given on this form is confidential (See Privacy Policy). I have the right to ask questions about my treatment appointments, and I can stop or modify it at any time. I understand that I am required to give **24 hours notice** to **cancel** appointments, or I may be charged for the missed appointment time.

Signature: _____ Date: _____

Date of Initial Health History: _____
Update 1 _____
Update 2 _____
Update 3 _____
Update 4 _____