Health History

Dawson Integrative Health
Holistic Health & Wellness

This information will assist us in treating you safely.
Please feel free to ask any questions about the information being requested.
All information on this form will be kept confidential unless given written permission from you or as required by law.

Date: _____
Update: _____
Update: _____
Update: _____

Last Name: _____ First Name: _____ Initial: _____ Male Female

Date of Birth: YYYY / MM / DD Occupation: _____

Address: _____ City: _____ Province: _____ Postal: _____

Home Phone: ( ) _____ Work Phone: ( ) _____ Cell / Email: _____

Physician and Emergency Contact Information:

Name: _____ Address: _____ Phone: ( ) _____

Name: _____ Address: _____ Phone: ( ) _____

Did someone refer you for massage? Yes No

If so, who? (Name and address) _____

Have you received massage before? Yes No How did you hear about us? _____

Are you being treated by other health professionals? Yes No

If yes, who is treating you and for what conditions? _____

List medications you are taking and the conditions they treat: _____

_____

Do you have any internal pins, wires, artificial joints or other special equipment? Yes No

If yes, indicate what and where: _____

What is your main complaint for today? _____

Where are you experiencing discomfort, tension or pain? _____

_____

Allergies (lotions, smells, oils): _____

_____

List surgeries/injuries and their dates: _____

_____

Have you taken medication in the past few hours? Yes No

Blood Pressure (To Be Taken):

Date: _____ Result: _____

Date: _____ Result: _____

Date: _____ Result: _____

Date: _____ Result: _____

Please indicate conditions you are experiencing (with a **'C' for *current***), have experienced (with a **'P' for *past***) or have a family history (with a **'H' for *family history***):

Cardiovascular

- [ ] High blood pressure
- [ ] Low blood pressure
- [ ] Heart disease/failure
- [ ] Heart attack
- [ ] Phlebitis or varicose veins
- [ ] Stroke (CVA)
- [ ] Pacemaker or similar device
- [ ] Cardiovascular difficulty
- [ ] Dizziness/vertigo

Respiratory

- [ ] Chronic cough
- [ ] Bronchitis
- [ ] Shortness of breath
- [ ] Asthma
- [ ] Emphysema
- [ ] Respiratory difficulty

Skin Conditions

- [ ] Eczema
- [ ] Psoriasis
- [ ] Rashes
- [ ] Warts
- [ ] Open sores or scars

Infectious Conditions

- [ ] Skin condition(s);
- [ ] Respiratory condition(s);
- [ ] Hepatitis
- [ ] HIV/AIDS
- [ ] Herpes
- [ ] Tuberculosis

Digestive

- [ ] Constipation or diarrhea
- [ ] Crohn's disease
- [ ] Irritable bowel syndrome
- [ ] Ulcers

Head and Neck

- [ ] Headaches/migraines
- [ ] Vision problems/loss
- [ ] Hearing problems/loss

Neurological

- [ ] Loss of sensation;
- [ ] Epilepsy or seizures

Musculoskeletal

- [ ] Neck / back pain
- [ ] Shoulder / elbow pain
- [ ] Wrist / hand pain
- [ ] Hip / knee pain
- [ ] Ankle / foot pain
- [ ] Arthritis or joint pain
- [ ] Scoliosis
- [ ] Osteoporosis

Other

- [ ] Diabetes or other endocrine system dysfunction
- [ ] Chronic fatigue / fibromyalgia
- [ ] Anxiety or panic attacks
- [ ] Cancer;

Women

- [ ] Pregnant; due date:
- [ ] Previous pregnancies
- [ ] Gynecological conditions

List any other conditions not mentioned above: _____

Overall, how is your general health? _____

Any other information you wish to provide: _____

_____

I agree that all information provided on this form is correct to the best of my knowledge and that any changes in my health must be brought to the attention of my therapist/practitioner and updated here. I understand the information provided will be kept confidential and will only be released with my prior written consent or as required by law.

Signature: _____ Date: _____