Domenic Massa, RMT, CST

registered massage therapy, craniosacral therapy

phone (519)433-7444 fax (519)433-1276

Health History Outline

Personal Information

Date: ____________________________

Name: ____

Address: ____ Apt# ______________

City: _____________ Prov: ________________ Postal Code: _______________

Who Referred You To This Clinic? ___________________________________

Date of Birth: ___________ (day / month / year) Age: _____ Gender: M/F

Weight: _____________ (lbs) Height: _________________

Phone Number: Home: ________________ Work: ____________________
Cell: ________________

Occupation: ____

Recreation Activities: _______________________________________

What Brings You In For Massage Treatment? _________________________

Please Circle The Treatment Modalities You Have Used in The Past.

Chiropractic Registered Massage Naturopathy CranioSacral
Reiki Reflexology Psychotherapy Acupuncture Shiatsu

Name:____________________ Date:____________________

On a scale of 1 to 5 (1 being mild and 5 being severe) please indicate which problems you have experienced

Neurological
__Allergies
__Chills
__Convulsions
__Dizziness
__Fainting
__Fevers
__Headaches
__Loss of Sleep
__Nervousness
__Depression
__Numbness
__Sweats
__Weight loss
__Tremors

Skin
__Boils
__Bruise Easily
__Dryness
__Hives/Allergies
__Itching
__Skin Rash
__Varicose Veins

Muscle and Joint
__Arthritis
__Bursitis
__Foot Pain
__Fallen Arches
__Hernia
__Low Back Pain
__Neck Pain
__Neck Stiffness
__Pain between Shoulders

Cardio Vascular
__Rapid Heart Beat
__Slow Heart Beat
__Swelling of Ankles
__Hardening of Arteries
__High Blood Pressure
__Low Blood Pressure
__Pain over Heart
__Poor Circulation

Gastro Intestinal
__Excessive Hunger
__Burping or Gas
__Liver Trouble
__Colitis
__Colon Trouble
__Constipation
__Difficult Digestion
__Distension of Abdomen
__Stomach Pain
__Gall Bladder Problems
__Hemorrhoids
__Intestinal Worms
__Jaundice
__Poor Appetite
__Nausea
__Vomiting
__Diarrhea

Respiratory
__Chest Pain
__Chronic Cough
__Difficulty Breathing
__Spitting Blood
__Excessive Phlem
__Wheezing

Genito-Urinary
__Bed Wetting
__Blood in Urine
__Frequent Urination
__Incontinance
__Kidney Infection
__Painful Urination
__Prostate Trouble

For Woman Only
__Cramps
__Heavy Flow
__Irregular Cycle
__No Menstration
__Pain During Cycle
__Mood Swings

EENT
__Colds
__Cross eyed
__Deafness
__Dental Decay
__Asthma
__Ear Aches
__Ear Discharge
__Ear Noises
__Sinus Infections
__Enlarged Glands
__Sore Throat
__Tonsilitis
__Eye Pain
__Failing Vision
__Far Sighted
__Gum Trouble
__Hay Fever
__Hoarseness
__Nose obstruction
__Near Sighted
__Nose bleeds

Current Medications / Supplements / Herbs:
Names and Condition Treated:____________________

Injuries or Accidents:
Dates / Description:____________________
Current Symptoms if Any:____________________

Surgery or Hospitalization:
Dates / Description:____________________
Current Symptoms if any:____________________

Family Doctor:____________________ **Phone #** ____________________
Address: ____________________

Is There Any Other Information You Would Like To Add?: ____________________

Lifestyle Habits

What do you do for exercise?____

What do you do for stress relief?____

Do you drink alcohol?(If yes how much?)______________________________________

How many glasses of water do you drink per day?____________________

Rate your sleep hours per night: 4-6 6-8 8-10 10-12 12+

Do you wake feeling rested?__________________

On a scale from 1 to 5 (1 being poor, 5 being excellent) rate your:

___Diet ___General Health
___Exercise ___Mental Attitude
___Energy

On a scale of 0 to 5 (0 being non-existant, 5 being extreme) please rate your stress levels in the following areas:

___Occupational ___Financial
___Family ___Health Status
___Relationships ___Previous Emotional Issues
___Social

Important 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 inform me before your next treatment. All information obtained is strictly confidential except as required by law or by your written authorization. You may ask questions at any given time for better understanding of what your treatment entails.

I understand that I must give 24 hours notice for cancellation of an appointment or to change an appointment time.

Payment by cash, visa or interact is due at the end of each visit.

Signature______________________________ Date___________________________