HEALTH HISTORY

PLEASE LIST THE FOLLOWING:

1.CURRENT MEDICATIONS/CONDITIONS TREATED PERTAINING TO CURRENT INJURY:

_____

2. INJURIES/SURGERIES, INTERNAL PINS, WIRES, ARTIFICIAL JOINTS: DATE, NATURE,

LOCATION:_____

Please circle any of the following that pertain to you:

RESPIRATORY/CARDIOVASCULAR

- Stroke/CVA
- Low/High Blood Pressure
- Heart Disease/Attack
- Chronic Congestive Heart Failure
- Varicose Veins/Phlebitis
- **PACEMAKER**/Similar Device
- Bronchitis
- Shortness of Breath
- Asthma
- Emphysema

INFECTIONS

- Hepatitis
- Skin Conditions
- TB
- HIV
- Herpes

HEAD/NECK

- History of Headaches/Migraines
- Vision Problems/Loss
- Ear Problems/Loss

WOMEN

- Pregnant, due:_____
- Gynaecological conditions, what?_____
- Overall how is your general health?_____

OTHER CONDITIONS

- Loss of Sensation, where?_____
- Diabetes, Onset_____
- Allergies/Hypersensitivity to what?_____
- Epilepsy
- Cancer, where?_____
- Arthritis

Do you have any other medical/health conditions? (e.g haemophilia, osteoporosis, mental illness, digestive conditions)_____
_____

If applicable, what is the reason you are seeking massage/physiotherapy? Please include the location of any tissue or joint discomfort._____

Client Signature:_____

Date:_____

Initial Health History_____	Update 4_____
Update 1_____	Update 5_____
Update 2_____	Update 6_____
Update 3_____	Update 7_____

The information requested above will assist us in treating you safely. Feel free to ask any questions about the information being requested. Please note that all information provided will be kept confidentially unless allowed or required by law. Your written permission will be required to release any information. FreeFlo Physiotherapy will be the Health Information Custodian for all health information obtained.