Sage Naturopathic Clinic
Feel Better - We Can Help
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Health History Form

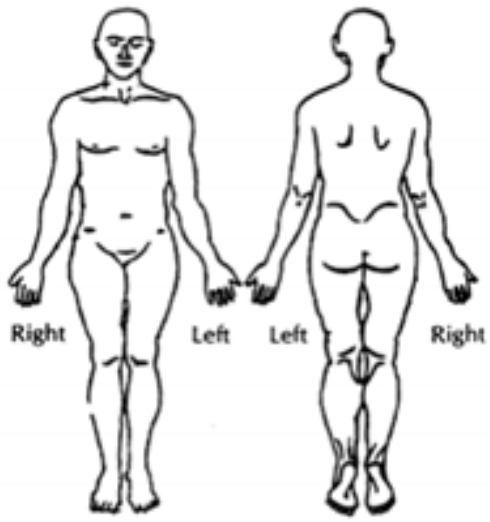
The information request below will assist us in treating you safely. Feel free to ask any questions about the information being requested.

Name: _____Date of Birth: _____
Address:_____
Phone # _____Occupation:_____

Primary Care Physician:_____
Address:_____

Have you received massage therapy before?□Yes□No
Did a healthcare practitioner refer you for massage therapy?□Yes□No

What is the reason you are seeking massage therapy?_____
_____



Please indicate the location of any tissue or joint discomfort:

_____
_____
_____
_____
_____

Overall, how is your general health?

_____
_____

Please indicate conditions you are experiencing or have experienced:

Cardiovascular
□high blood pressure
□low blood pressure
□chronic congestive heart failure
□heart attack
□phlebitis / varicose veins
□stroke/CVA
□pacemaker or similar device
□heart disease
is there a family history of any of the above? □ Yes □ No

Head/Neck
□history of headaches
□history of migraines
□vision problems
□vision loss
□ear problems
□hearing loss

Respiratory
□chronic cough
□shortness of breath
□bronchitis
□asthma
□emphysema
is there a family history of any of the above? □ Yes □ No

Infections
□hepatitis
□skin conditions
□TB
□HIV
□herpes

Women
pregnant, due:_____
gynaecological conditions:
what?_____
_____

Other Conditions
loss of sensation, where?
_____

diabetes,type/onset: _____

allergies/hypersensitivity to
what?
_____
type of reaction: _____

Epilepsy □Yes □ No
Cancer, where?
_____
Skin conditions, what?
_____

Arthritis □Yes □ No
Is there a family history of arthritis?
□Yes □ No

Do you have any internal pins, wires, artificial joints or special equipment ? □Yes □ No
If yes, location?
_____
_____

Have you have any surgeries or physical trauma? □ Yes □ No
If yes, when and location:
_____
_____
_____
_____

Do you have any other medical conditions? (e.g. digestive conditions, haemophilia, osteoporosis, mental illness) □Yes □ No
_____
_____