Innercore Health

Date____________________

Health History Form

Please complete form in full.

Name:		Date of birth	Day / Month / Year
Address		City	Postal code
Phone: home			
cell		Email address	
work		Occupation	
Preferred contact		Referred by	
How did you hear about us?			

If your health status changes in the future please let us know. All information gathered is confidential except as required by law. You will be asked to provide written authorization for release of any information.

: 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

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

Other Conditions
- ☐ loss of sensation, where? ____________
- ☐ diabetes, onset: ____________
- ☐ allergies/hypersensitivity to what? ____________

type of reaction: ____________
- ☐ epilepsy
- ☐ cancer, where? ____________
- ☐ skin conditions, what? ____________
- ☐ arthritis

is there a family history of arthritis? ☐ Yes ☐ No

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

Women
- ☐ pregnant, due:____________
- ☐ gynaecological conditions, what?____________

Overall, how is your general health? ____________

Primary Care Physician: ____________

Address: ____________

Current Medications: ____________

condition it treats: ____________

Are you currently receiving treatment from another health care professional? ☐ Yes ☐ No
If yes, for what? ____________

Surgery – date ____________
nature: ____________

Injury – date ____________
nature: ____________

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

Do you have any internal pins, wires, artificial joints or special equipment ? ☐ Yes ☐ No
what? ____________
where? ____________

What is the reason you are seeking massage therapy? Please include the location of any tissue or joint discomfort.

____

Update ____________

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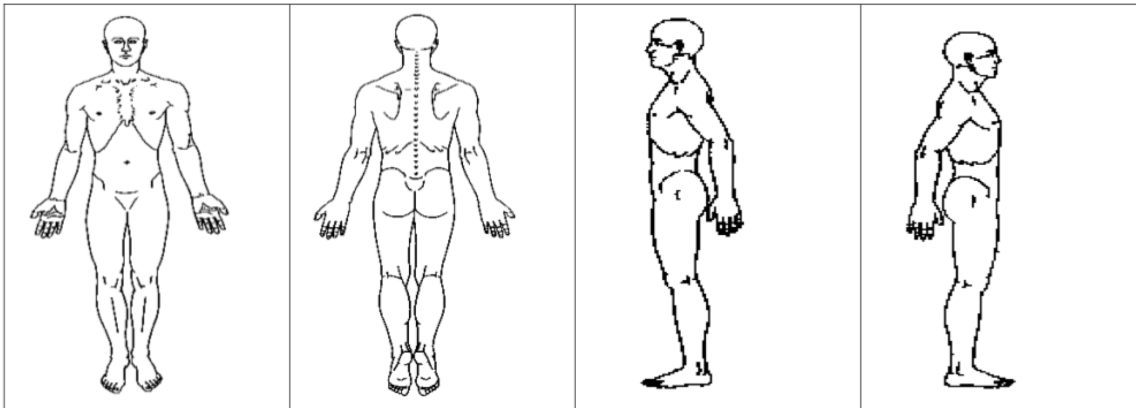
Date_____________________

Main Complaint

Numbness OOOO OOOO Burning ✗✗✗✗ ✗✗✗✗ Stabbing /////// /////// Pins & Needles ●●●● ●●●● Aching ✳✳✳✳✳ ✳✳✳✳✳



Location of the pain. Please use the diagrams. Try to be as specific as you can.
____
Cause of the pain: ____
How long have you had the pain? ____
How frequent is the pain? (all day/night/only when you get up?) ____________________________
How intense is the pain? (scale of 1 –10) ____
How would you describe the pain? (achy, throbbing, burning) ____________________________
What makes the pain increase? ____
What makes the pain decrease? ____
What medications are you presently taking for the condition (muscle relaxants, painkillers?)?
____
Is there a history of this condition? ____
Have you received any other treatment for this condition? If yes, please describe and comment on its success.
____
What results do you desire from your treatment? ____________________________________

Have you received massage therapy previously? Yes No

Update _______________
____
____
____