MacEwan UNIVERSITY | MASSAGE THERAPY

Massage Therapy Teaching Clinic
CONFIDENTIAL HEALTH HISTORY FORM

The personal information requested on this form is collected under s.33(c) of the Freedom of Information and Protection of Privacy Act for the purpose of Massage Therapy student practice at MacEwan University. Questions concerning this collection should be directed to the Lead, Privacy and Information Management at privacy@macewan.ca.

The information requested will assist us in treating you safely. Feel free to ask any questions about the information being requested. Your written permission will be required to release any information to a third party.

Date: _____

Name: _____ Home Phone: _____

Address: _____ Cell Phone: _____
Street # Apt. #

_____ Work Phone: _____
City Province Postal Code

Date of Birth: _____ Occupation: _____ Email: _____
day month year

MacEwan University offers the service of appointment reminders by email.
I understand the risks/benefits of email transmission and request that future reminders be sent electronically to the above email address (please check one): YES ☐ NO ☐

Age: _____ Weight: _____ Height: _____ Gender: _____ Preferred Pronoun: _____

Emergency Contact:_____Phone Number(s):_____Relationship: _____

Medical Doctor:_____ Doctor Phone #: _____

Other Healthcare: ☐ chiropractor ☐ massage therapy ☐ physiotherapist ☐ naturopathic doctor ☐ nutritionist/dietician

Other (specify): _____

Major complaint: _____

_____

Are you currently experiencing any: ☐ pain ☐ tingling ☐ numbness ☐ stiffness

Location: _____

Allergies:_____

_____

Please list **ALL** medications you are currently taking (prescription, non-prescription, over the counter, narcotics, vitamins, minerals and/or herbal supplements). Indicate name, dosage and the times that each are taken:

_____

_____

_____

Surgeries (please indicate type and date):

_____

_____

Injuries within the last 5 years (please indicate area(s), date of injury, and if resolved): _____

_____

_____

Have you previously received massage? ☐ yes ☐ no

Please check (✓) any of the following that apply to you:

Cardiovascular System
- ☐ aneurysm
- ☐ high blood pressure/hypertension
- ☐ low blood pressure/hypotension
- ☐ heart conditions
- ☐ stroke
- ☐ varicose veins
- ☐ phlebitis
- ☐ pacemaker
- ☐ angina / chest pains
- ☐ atherosclerosis

Nervous System
- ☐ Multiple Sclerosis
- ☐ Parkinsons
- ☐ seizures/epilepsy
- ☐ carpal tunnel syndrome

Other (specify):

_____
_____
_____
_____

Respiratory Systems
- ☐ bronchitis
- ☐ asthma
- ☐ emphysema
- ☐ sinusitis
- ☐ chronic cough
- ☐ breathing problems / shortness of breath

Other (specify):

_____
_____
_____

Digestive/ Urinary Systems
- ☐ ulcers
- ☐ constipation / diarrhea
- ☐ ulcerative colitis
- ☐ Crohn's disease
- ☐ gall stones
- ☐ irritable bowel syndrome (IBS)
- ☐ nausea
- ☐ kidney disease
- ☐ bladder / voiding problems
- ☐ liver disease

Other (specify):_____

_____
_____

Skin
- ☐ plantar warts
- ☐ eczema
- ☐ psoriasis
- ☐ rashes
- ☐ bruise / cuts / open sores
- ☐ fungal infection (ex. Athlete's foot)
- ☐ herpes simplex / cold sores
- ☐ areas of sensitivity

Other (specify):

_____
_____
_____
_____

Reproductive Systems
- ☐ menopausal problems
- ☐ painful menstruation
- ☐ pregnant or trying

Due date:

_____
- ☐ caesarean section
- ☐ endometriosis

Other (specify):

_____
_____
_____
_____

Muscles and Joints
- ☐ fibromyalgia
- ☐ chronic fatigue syndrome
- ☐ osteoporosis
- ☐ arthritis

Specify type and location:

_____
_____
_____
- ☐ metal plates / screws / medicinal patches / prosthetic devices

Specify type and location:

_____
_____

Areas affected:
- ☐ head/neck
- ☐ mid back
- ☐ jaw /TMJ
- ☐ shoulder
- ☐ elbow
- ☐ wrist/hand
- ☐ chest
- ☐ abdomen
- ☐ low back
- ☐ pelvis
- ☐ hip
- ☐ knee
- ☐ ankle/foot

Other
- ☐ contagious disease
- ☐ hepatitis
- ☐ HIV/AIDS
- ☐ diabetes
- ☐ chronic fatigue syndrome
- ☐ sleep apnea
- ☐ anxiety / depression / tension /stress
- ☐ tumours/cysts
- ☐ hernias
- ☐ swelling extremities /nodes /glands
- ☐ hormone imbalances
- ☐ cancer

Specify:_____

_____

Other (specify):_____

_____
_____
_____
_____

Head/Neck
- ☐ headaches (cluster / tension / migraines)
- ☐ vision problems or loss
- ☐ hearing / ear problems
- ☐ dizziness/ fainting
- ☐ dentures
- ☐ contact lenses

_____

Sleep
- ☐ adequate
- ☐ too much
- ☐ too little

_____

Physical activity
- ☐ none
- ☐ low (1- 2 x per week)
- ☐ moderate (3 – 4 x per week)
- ☐ high (5 x + per week)

Type: _____
_____
_____

I understand that I am a voluntary client for clinical practice at MacEwan University's public massage clinics. A supervisor is present at all times and may come into the room to observe and facilitate student learning. Student practitioners are not qualified to diagnose and this treatment is not intended to replace medical, physical therapy or chiropractic treatment.

I understand the MacEwan University Massage Therapy Teaching Clinic **cannot** treat patients with injuries and/or conditions resulting from motor vehicle accidents or workplace accident. I acknowledge the Clinic **cannot** supply reports to third parties such as insurance companies, lawyers, or the Workers' Compensation Board.

By my signature below I authorize that the information provided is to the best of my knowledge and release MacEwan University, their employees, and students from any kind of claim.

Patient Signature: _____ Date: _____
(Parent/Guardian signature required if patient is under 18 years of age)