Body Renewal Health Centre

Health History

Name: _____ Email: _____

Address: _____ City: _____ Postal Code: _____

Home Phone: _____ Cell: _____ Work: _____

Would you like an appointment reminder? ☐ Yes ☐ No How? ☐ email ☐ phone

Date of Birth (dd/mm/yy): _____ Age: _____ Occupation: _____

Doctor's Name: _____ Doctor's Phone: _____

Emergency Contact: _____ Relationship: _____ Phone: _____

Do you currently have health coverage / type: _____

How did you hear about us? _____

Have you had a professional massage before? ☐ Yes ☐ No

Approximate date of last therapeutic massage: _____

Have you had prior chiropractic care? ☐ Yes ☐ No

Approximate date of last adjustment: _____

Do you see any other healthcare practitioners?

☐ Physio ☐ Naturopath ☐ Osteopath ☐ Other: _____

Do you have any sensitivity to scents, oils, lotions or ointments: ☐ Yes ☐ No

If yes, please explain: _____

Have you had any major illnesses, falls, surgeries or been involved in a ***motor vehicle*** or ***workplace*** accident?

Describe:_____

_____

Please list current medications and the conditions they treat: _____

_____

Family History of: _____

_____

Lifestyle:

Do you exercise?	☐ Yes	☐ No	How often? _____		
Do you smoke?	☐ Yes	☐ No			
Alcohol consumption	☐ Never	☐ Occasional	☐ Often		
Sleep (hours per night)	☐ 4-6	☐ 6-8	☐ 8-10	☐ 12+	
Is it solid sleep:	☐ Yes	☐ No			
Rate your diet:	☐ Poor	☐ Fair	☐ Good	☐ Excellent	
Meals per day:	☐ 1	☐ 2	☐ 3	☐ 4	☐ More than 4 meals
Drink plenty of water	☐ Yes	☐ No			

TURN OVER

Please check all that apply to you presently and/or in the past.

General Symptoms
___ Fainting / Dizziness
___Difficulty Sleeping / Fatigue
___ Stress
___ Headaches / Migraines
___ Nervousness
___ Numbness / Tingling; Where: _____
___ Paralysis

EENT (eye, ear, nose, throat)
___ Vision Problems
___ Glasses / Contacts
___ Dental Problems
___ Sore Throat
___ Ear Aches
___ Hearing Difficulty
___ Hearing Aid
___ Sinus Problems
___ Frequent Colds

Infections
___ Tuberculosis
___ Hepatitis
___ HIV / AIDS
___ Athlete's Foot
___ Warts

Skin
___ Excessive Dryness
___ Psoriasis
___ Eczema
___ Bruise Easily

Soft Tissue / Joints
___ Pain / Stiffness
___ Swelling
___ Limitation of Movement
___ Back Pain
___ Neck Pain
___ Bursitis
___ Arthritis; Type: _____

Cardiovascular
___ High Blood Pressure
___ Low Blood Pressure
___ Chest Pain
___ Heart Attack / Disease
___ Congestive Heart Failure
___ Stroke / Aneurysm
___ Heart Murmur
___ Pacemaker
___ High Cholesterol
___ Poor Circulation
___ Varicose Veins / Phlebitis

Gastrointestinal
___ Constipation
___ Diarrhea
___ Nausea / Vomiting
___ Gall Bladder Problems
___ Liver Problems
___ Acid Reflux

Abdominal
___ Cramping
___ Hernia
___ Colitis / Crohn's / Celiac
___ IBS
___ Diverticulitis
___ Kidney / Bladder Problems
___ Frequent Urination

Other Conditions
___ Diabetes; Onset: _____
___ Cancer; Where: _____
___Epilepsy
___ Neuromuscular Conditions
___ Multiple Sclerosis
___ Osteoporosis
___ Fibromyalgia
___ Thyroid Problems
___ Hyper / Hypo Glycaemia
___Depression
___ Mental Illness
___ Pins / Plates / Wires; Where: _____
___ Prosthesis; Type: _____

For Women Only
___ Painful Menstruation
___ Irregular Periods
___ PMS
___Menopausal
___ IUD
___ Pregnant; Weeks: _____

What is your **main** complaint that you would like to address at today's appointment:

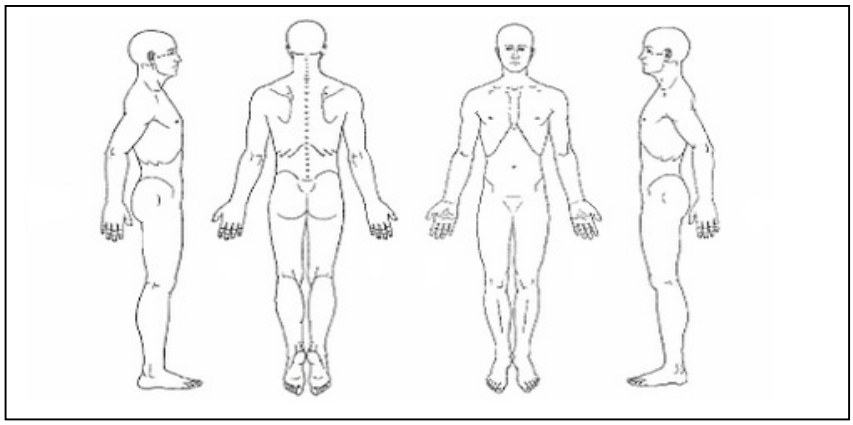
_____

_____

_____

_____

Please circle all areas of pain and/or discomfort



- The information on this form is confidential and will be used for no other purpose than for your Massage Therapy and/or Chiropractic treatment unless consent is obtained from you.
- **Cancellation Policy:** Appointments can be cancelled without charge, provided 24 hours notice has been given. Please call our office at 506-459-2639. If less than 24 hours is given or if an appointment is missed, a fee of half of your appointment cost will apply as your treatment time has been reserved for you.

I verify that the information I have given on this form is true and complete to the best of my knowledge. I have read and understand the cancellation policy.

_____ _____

Signature Date