ReNu Health & Wellness

Please take a moment to fill out this confidential health history form. This will ensure that you receive the proper treatment and that it is safe to do so. Thank you!

PERSONAL INFORMATION:

Date: Da_____ Mo_____ Yr_____

Name: _____ Occupation: Retired / Student / Working_____

Address: _____ City: _____ Postal Code: _____

Home phone: _____ Business Phone : _____ Cell phone: _____

Email: _____ Is it a problem to contact you by any of these methods? _____

Date of Birth: M __ D ___ YR ___ Height: _____ Estimated Weight: _____ Sex: M / F

Do you have Extended Health Care benefit for massage therapy treatments? Y / N

If referred by who? _____

Doctor's Name and Address: _____

CHIEF PHYSICAL COMPLAINT:

Are you here for relaxation only? Y / N If yes skip the next six questions

What are your primary aches and pains? _____

Can you describe it? Dull Sharp Shooting Achy Numb Tingling Stiff Does it radiate anywhere? _____

When did they begin / what were you doing? _____

What aggravates your symptoms? _____

What relieves your symptoms? _____

Are these symptoms interfering with: Work Sleep Daily Life

PLEASE CHECK WHICH OF THE FOLLOWING APPLY TO YOU:

	Present	*Past*	*Right*	*Left*
1. Head/Neck:				
Headache	_____	_____	_____	____
Whiplash	_____	_____	_____	____
Vision Problems	_____	_____		
Dizziness	_____	_____	_____	____
Any Head Trauma	____	_____	_____	____
Migraines	_____	_____		
Hearing Loss	_____	_____	_____	____
2. Muscle Stiffness/Soreness				
Neck/Shoulders	_____	_____	_____	____
Upper/Mid Back	_____	_____	_____	____
Lower Back	_____	_____	_____	____
Legs	_____	_____	_____	____
Knees	_____	_____	_____	____
Arms	_____	_____	_____	____
Hands/ Feet	_____	_____	_____	____
Hips	_____	_____	_____	____
Loss of Sensation	_____			

3. Males Only

Prostate Cancer Y / N

Testicular cancer Y/ N

If yes indicate year_____

4. Infectious Conditions

Tuberculosis _ HIV__ HEP __

	Yes	No
5. Digestive Disorders:		
Constipation	_____	_____
Diarrhea	_____	_____
Difficult Digestion	_____	_____
Colitis	_____	_____
Crohn's	_____	_____
Hernia	_____	_____
6. Cardiovascular:		
High Blood Pressure	_____	_____
Low Blood Pressure	_____	_____
Poor Circulation	_____	_____
Heart Disease	_____	_____
Shortness of Breath	_____	_____
Varicose Veins	_____	_____
Phlebitis	_____	_____
Pace Maker	_____	_____
7. Skin Disorders:		
Rashes	_____	_____
Allergies	_____	_____
Cold Sores	_____	_____
Psoriasis	_____	_____
Eczema	_____	_____

See Other Side→..→..→..→..→..→..→

8. Respiratory: **Yes** **No**

Smoking (# a day__)	_____	_____
_Asthma _Emphysema	_____	_____
Bronchitis	_____	_____
Chronic Cough	_____	_____
Shortness of breath	_____	_____

9. Other Disorders:

Cancer	_____	_____
Diabetes	_____	_____
HIV	_____	_____
Epilepsy	_____	_____
Hepatitis	_____	_____
Osteoporosis	_____	_____
Arthritis	_____	_____
Blood Disorder	_____	_____
Fainting / Dizzy	_____	_____
Pins/wires/artificial joints	_____	_____

10. Females Only:
Menstrual Problems:
Painful Y / N
Heavy Y / N
Scant Y / N
Previous Pregnancy's: #_____
Pregnant: Expecting when_____
Note: massage can assist in menstrual and pregnancy discomforts.

EXERCISE AND ACTIVITY INFORMATION
Yes___ none at this time____
1. How often do you exercise or do physical activity outside of your daily job_____/week
2. What type of exercise or activity do you do
_____
_____

MEDICAL INFORMATION:
Note: Please inform us at every treatment if this information changes

Medications, Herbs and Vitamins
It is important for us to be aware of any medications consumed, please list any medications you are currently using or any that you have used recently:
Name:_____ For What:_____ Dosage:_____
Name: _____ For What: _____ Dosage: _____
Name:_____ For What: _____ Dosage: _____
Name:_____ For What:_____ Dosage:_____

Surgeries and Injuries (Major and/or minor):
Any past surgeries, injuries, or car accidents are important for complete medical history. Please list.
Incident:_____ Date: _____
Incident:_____ Date:_____
Incident:_____ Date:_____
Incident:_____ Date:_____

Have You Had Other Health Care (please indicate):

	Name of Practitioner (past or current)	**Last Date of Treatment**
Massage Therapy: Y/N	_____	_____
Chiropractic Care: Y/N	_____	_____
Physiotherapy: Y/N	_____	_____
Acupuncture: Y/N	_____	_____
Any other therapies?	_____	_____

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PLEASE READ CAREFULLY AND SIGN BELOW

1. Any appointments that are not cancelled with 24 hours notice will be levied a $30 charge.
2. If you are the legal guardian of a patient it is your responsibility for the payment of this patient.
3. Most Extended Health Care plans offer coverage for Massage Therapy. ReNu collects payments from clients at the time of treatment, the patient then submits the receipt for reimbursement from their particular insurance company. You may also save your receipts as a medical tax expense on your personal income tax.
4. By my signature below, I authorize the collection, use and disclosure of personal information as defined in the Personal Information and Protection Act (PIPA), required for treatment or any related administration purpose. I understand that all my information is confidential and must be treated in accordance with the PIPA.

Signature_____ Date: DA____ MO____ YR_____

REVIEWED FORMS
Year: ____ Int: ____ Year: ____ Int:____ Year:_____ Int:____