ReNu Health & Wellness

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

PERSONAL INFORMATION:

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
Referred By? _____
Doctor's Name and phone #: _____

CHIEF PHYSICAL COMPLAINT:

Note: If you are here for relaxation or maintainance you may skip this section
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 __

See Other Side…….

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:	_____	_____
Exema:	_____	_____
Other:	_____	

8. Respiratory:

Smoking:	_____	_____
_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:
Menstral Problems:
Painful Y / N
Heavy Y / N
Scant Y / N
Previous Pregnancy's: #_____
Pregnant: Expecting when_____
Note: massage can assist in menstral 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:	Y/N	(if yes please specify: _____)	

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:__
Year: __ Int: __ Year: __ Int:__ Year:__ Int:__