Gleeson Clinic ***Massage/Acupuncture Health History***

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Please complete this form in full. All information is strictly confidential.

General Information

Name: _____ Date: _____
Address: _____ Birth Date: _____
City: _____ Province: _____ Postal Code: _____
Preferred Phone: _____ Alternate Phone: _____
Height: _____ Weight: _____ Max. Weight: _____ When: _____
Occupation: _____ Have you had massage before: _____
How did you hear about our clinic? _____

Focus *List major complaints in order of importance.*

Complaint	Since	Causes

Review of Symptoms *Only mark if a problem, 1=occasional difficulty 2=frequent difficulty 3=regular difficulty*

1 2 3		1 2 3		1 2 3	
☐ ☐ ☐	weight loss or gain	☐ ☐ ☐	fevers	☐ ☐ ☐	gas
☐ ☐ ☐	fatigue	☐ ☐ ☐	dizziness	☐ ☐ ☐	abdominal pain
☐ ☐ ☐	hair loss	☐ ☐ ☐	ringing in ears	☐ ☐ ☐	nausea/vomiting
☐ ☐ ☐	sexual difficulties	☐ ☐ ☐	earaches	☐ ☐ ☐	difficult digestion
☐ ☐ ☐	poor endurance	☐ ☐ ☐	blurry vision	☐ ☐ ☐	fatty foods agravate
☐ ☐ ☐	confusion	☐ ☐ ☐	eyestrain	☐ ☐ ☐	constipation
☐ ☐ ☐	nervousness	☐ ☐ ☐	nasal congestion	☐ ☐ ☐	diarrhea
☐ ☐ ☐	depression	☐ ☐ ☐	sinus pressure	☐ ☐ ☐	thin stool
☐ ☐ ☐	insomnia	☐ ☐ ☐	nosebleeds	☐ ☐ ☐	straining
☐ ☐ ☐	nightmares	☐ ☐ ☐	hayfever	_____	number of bowel
☐ ☐ ☐	muscle tension	☐ ☐ ☐	swollen glands		movements daily
☐ ☐ ☐	muscle cramps	☐ ☐ ☐	mucous problems	_____	is this a change (y/n)
☐ ☐ ☐	numbness/tingling	☐ ☐ ☐	sores in mouth	☐ ☐ ☐	hemorrhoids
☐ ☐ ☐	cold hands/feet	☐ ☐ ☐	coated tongue	☐ ☐ ☐	bloody or black stools
☐ ☐ ☐	sweaty hands/feet	☐ ☐ ☐	bad breath	☐ ☐ ☐	night urination
☐ ☐ ☐	blackouts	☐ ☐ ☐	sore throats	☐ ☐ ☐	urinary problems
☐ ☐ ☐	itching	☐ ☐ ☐	dental problems	☐ ☐ ☐	burning on urination
☐ ☐ ☐	rashes	☐ ☐ ☐	neck pains	☐ ☐ ☐	bladder/kidney infection
☐ ☐ ☐	acne	☐ ☐ ☐	cough	☐ ☐ ☐	bedwetting
☐ ☐ ☐	eczema	☐ ☐ ☐	difficult breathing	☐ ☐ ☐	blood in urine
☐ ☐ ☐	psoriasis	☐ ☐ ☐	shortness of breath	☐ ☐ ☐	back pains
☐ ☐ ☐	warts	☐ ☐ ☐	coughing blood	☐ ☐ ☐	leg swelling
☐ ☐ ☐	change in mole	☐ ☐ ☐	heart palpitations	☐ ☐ ☐	bone or joint pain
☐ ☐ ☐	bruise easily	☐ ☐ ☐	chest pains	☐ ☐ ☐	arm/leg problems
☐ ☐ ☐	headaches	☐ ☐ ☐	breast lumps/pain	☐ ☐ ☐	joint swelling

Other: _____

Medical History

Personal Physician: _____ Telephone: _____

Date of last physical: _____

Are you pregnant? _____ What is your due date?_____

Are you allergic to medicines? Which ones? _____

_____

Are you allergic to foods? Which ones? _____

_____

Are you allergic to the environment? What? _____

_____

Please list any regular medications, prescriptions or over the counter, that you take: _____

_____

Please list any regular vitamin, mineral or herbal supplements you take: _____

_____

Please list any major operations you have had, and the year: _____

_____

_____

Please list any major injuries or accidents that you have had, and the year: _____

_____

_____

Please list any major illnesses or hospitalizations that you have had, and the year: _____

_____

_____

Write the approximate year that you have incurred any of the following conditions:

____ anemia	____ drug reaction	____ hypoglycaemia	____ parasite
____ arthritis	____ eczema	____ jaundice	____ pneumonia
____ asthma	____ emphysema	____ kidney infection	____ psoriasis
____ bladder infection	____ epilepsy	____ kidney stones	____ rheumatic fever
____ blood transfusion	____ gallstones	____ LB pressure	____ skin boils
____ bronchitis	____ heart attack	____ measles, German	____ syphilis
____ cancer	____ heart disease	____ measles, regular	____ tuberculosis
____ chicken pox	____ hepatitis	____ mental problems	____ ulcer
____ colitis	____ HB pressure	____ migraines	____ whooping cough
____ diabetes	____ HIV/AIDS	____ mumps	
____ diphtheria	____ hives	____ obesity	

Any other medical diagnosis you have from the past or present: _____

_____

Exercise Information

How often do you exercise weekly? _____

What form of exercise? _____

How long do you exercise? _____

I certify that the information given in this form is true and accurately reflects my past and present health status.

Client's Signature _____ Date _____