

PROMEDMA Clinic

#102 9807 34 ave
Edmonton, AB T6E 5X9
780-468-6878
info@promedma.com



HEALTH HISTORY FORM

Date: _____

PATIENT INFORMATION

Full name: _____
Address: _____
City: _____ Postal Code: _____
Phone: (C) _____
Date of Birth M/D/Y: _____
Physicians name: _____ Phone: _____
Other health care practitioner's name: _____ Phone: _____
Other Treatment types received/reason: _____
Emergency Contact: _____ Phone no: _____
Relationship to Patient: _____
Email Address for appointment reminders: _____
Employer and Occupation: _____
Benefits Provider: _____
How did you hear about us?: _____
Have you had Massage Therapy before, if so when: _____
Allergies: _____

PATIENT HISTORY

Medications: _____
Injuries: _____
Surgeries: _____
Primary Complaint: _____
Is this a work related injury, WCB claim? YES _____ NO _____
If YES, Have you reported this to your Physician and WCB, Date of injury, and what happened? _____

Is this a MVA (Motor Vehicle Accident) YES _____ NO _____ Date of MVA _____
Claim # _____ Adjuster Name and phone # _____

**PATIENT HISTORY PLEASE
CHECK OFF ANY CONDITIONS THAT APPLY
TO YOU**

HEADACHES

- Chronic Daily Headache
- Cluster
- Headaches
- Migraines
- Rebound
- Sinus
- Tension

BLOOD

- Anemia
- Bleeding Disorder
- Haemophilia
- Hepatitis
- HIV
- HIV/AIDS
- Hypercoagulability
- Polycythemia
- Thrombosis/Embolism

CARDIOVASCULAR

- Acute Coronary Syndrome
- Aneurysm
- Atherosclerosis
- Blood Clots-current_____ past_____
- Cardiac Arrhythmia
- Cardiovascular Accident
- Cardiovascular Conditions
- Chronic Ischemic Heart Disease
- Chronic Venous Insufficiency
- Cold Feet-left_____ right_____
- Cold Hands-left_____ right_____
- Congenital Heart Defect
- Congestive Heart Failure
- Coronary Artery Disease
- Heart Attack-when_____
- Heart Disease
- High Blood Pressure
- Hyperlipidemia
- Low Blood Pressure
- Lymphedema
- Myocardial Infarction
- Pacemaker
- Pericarditis
- Phlebitis
- Raynaud Disease
- Rheumatic Heart Disease
- Valve Disorders
- Varicose Veins

EMOTION & MEMORY

- Alzheimer Disease

- Anxiety Disorder
- Mood Disorder
- Schizophrenia
- Stress
- Substance Use Disorder

ENDOCRINE

- Acute Pancreatitis
- Diabetes-Type_____
- Hyperthyroidism
- Hypothyroidism
- Pituitary and Growth Disorder

GASTROINTESTINAL

- Celiac Disease
- Constipation- current_____ past_____
- Crohn's Disease
- Diarrhea-current_____past_____
- Digestive Conditions
- Diverticulitis
- Eating Disorder
- Esophageal Disorder
- Fecal Impaction
- Intestinal Polyps
- Irritable Bowel Syndrome
- Poor Appetite
- Stomach Disorder
- Ulcerative Colitis

HEARING

- Conductive Hearing Loss
- Ear Problems
- Hearing Loss
- Meniere Disease
- Motion Sickness
- Loss of balance
- Tinnitus
- Vertigo

IMMUNE

- Allergies-To what_____
- Anaphylaxis
- Cancer-current_____past_____
- Hodgkin Lymphoma
- Infectious Mononucleosis
- Leukemia
- Lupus
- Non-Hodgkin Lymphoma
- Rheumatoid Arthritis

KIDNEY

- Bladder Disorder
- Chronic Kidney Disease
- Congenital Kidney Disease
- Electrolyte Imbalance
- Kidney Stones-current_____ past_____
- Renal Cysts
- Urinary Incontinence

- Urinary Tract Infection

MUSCULOSKELETAL

- Amyotrophic Lateral Sclerosis (ALS)
- Ankylosing Spondylitis
- Arthritis
- Artificial Joints/Special Equipment
- Bone Disease
- Compartment Syndrome
- Dislocation
- Fibromyalgia
- Fracture-when _____
where _____
- Gout Left _____ Right _____
- Hereditary/Congenital Deformity
- Jaw Pain (TMJD)
- Joint Injury-when _____
where _____
- Muscular Dystrophy
- Myasthenia Gravis
- Osgood-Schlatter Disease
- Osteoarthritis
- Osteomalacia
- Osteoporosis
- Paget Disease
- Psoriatic Arthritis
- Scleroderma
- Scoliosis
- Sinus Problems
- Strain/Sprain-when _____
Where _____

NEUROLOGICAL

- Brain Disorder
- Brain Injury
- Burning-where _____
- Cerebral Palsy
- Cerebral Vascular Accident (Stroke)
- Chronic Pain Disorder
- Dizziness
- Epilepsy
- Herniated Disc-where _____
- Huntington Disease
- Loss of Sensation-where _____
- Multiple Sclerosis
- Numbness- where _____
- Parkinson's
- Seizure Disorder
- Shingles-current _____ past _____
- Stabbing-where _____
- Stroke-when _____
- Tingling-where _____
- Transient Ischemic Attacks (TIA)
- Vertebral and Spinal Cord Injury-When _____

REPRODUCTIVE

- Breast Disorder
- Ectopic Pregnancy
- Endometriosis
- Gynaecological Conditions
- Menopause
- Menstrual Cycle Disorder
- Ovarian Cysts/Tumors
- Pelvic Inflammatory Disease
- Pregnancy-how many _____
of children born _____
- Premenstrual Syndrome
- Uterine Disorder

RESPIRATORY

- Asthma
- Bronchitis
- Chronic Cough
- COPD
- Cystic Fibrosis
- Emphysema
- Infectious Respiratory Conditions
- Respiratory Conditions
- Respiratory Tract Infection
- Shortness of Breath

SKIN

- Acne
- Allergic Dermatitis
- Athlete's Foot
- Bruise Easily
- Chemical Burn
- Herpes
- Hypersensitive Reactions
- Infectious Skin Conditions
- Melanoma/Carcinoma
- Pigmentary Disorder
- Planter's Wart Left _____ Right _____
- Psoriasis
- Rash- Where _____
- Rosacea
- Skin Conditions
- Skin Irritations
- UV Burn- current _____ past _____

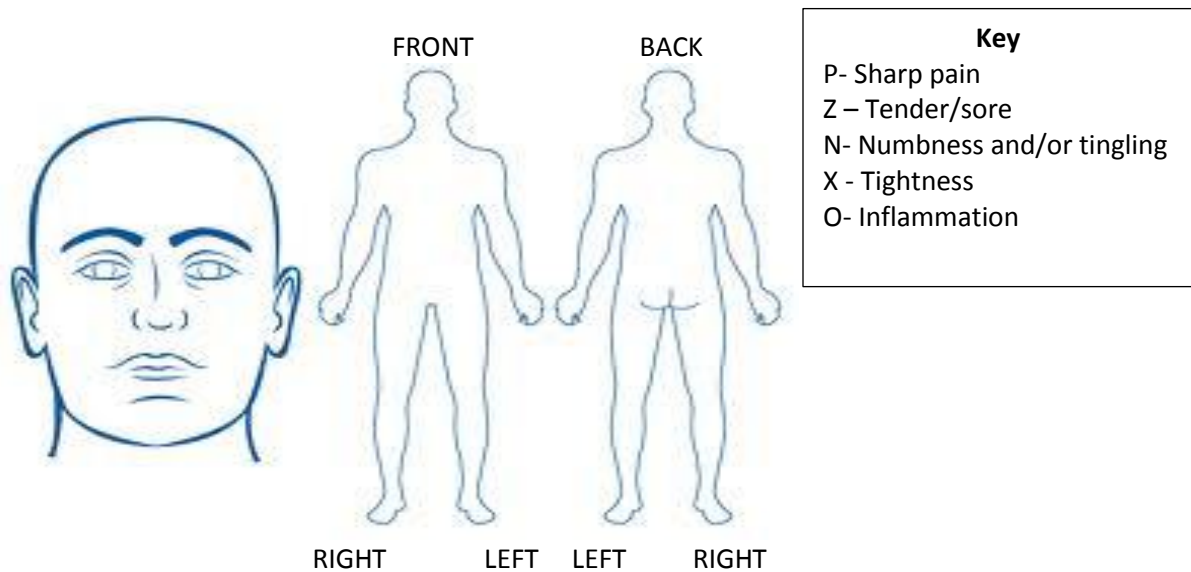
MISCELLANEOUS

- Insomnia
- Mental Illness
- Other Diagnosed Diseases _____
- Other Medical Conditions _____
- Surgical Pins or Wire-where _____
- Vision Loss
- Vision Problems

Family History

- Arthritis
- Cardiovascular
- Respiratory

Please indicate on diagram where you are experiencing any soreness, problems or concerns.



*Please note that creams used for massage therapy treatments may contain nut and/or fish products. If you have allergies to nuts or fish please notify the clinic and RMT prior to treatment so alternative creams can be used. Please initial that you have read the above statement: _____

*I understand that any illicit, sexually suggestive or inappropriate remarks made by me will result in immediate termination of the session and I will be liable for payment of the full scheduled appointment.

*I have informed the Massage Therapist of all my known physical conditions, medical conditions, medication and I will keep the Massage Therapist updated on any changes to my health prior to any treatments.

*As well I understand the Massage Therapy is NOT a substitute for medical treatments or medications and that I will continue to work with my Primary Caregiver for any conditions I may have.

*I also understand the Massage Therapists DO NOT diagnose illness or disease and will NOT prescribe any medications to me.

*I give Promedma and/or the RMT permission to contact my physician to discuss any concerns the RMT may have with muscular conditions I present. YES _____ NO _____.

Signature: _____ Date: _____

***No tipping at PROMEDMA. Thank you for your understanding