Health History Form

The information request below will assist us in treating you safely. Feel free to ask any questions about the information being requested. Please note that all information provided below will be kept confidentially unless allowed or required by law. Your written permission will be required to release any information.

Name:_____ Sex:___ Date of Birth: (mm)___(dd)___(yyyy)_____Phone:_____
Address:_____ City:_____Postal Code:_____Occupation:_____
Have you received massage therapy before? ☐Yes ☐No
Have you received acupuncture before? ☐Yes ☐No
Did a health care practitioner refer you for massage therapy/acupuncture? ☐Yes ☐No
If yes, please provide their name and address._____
_____

Please indicate conditions you are experiencing or have experienced:

Cardiovascular
- ☐ High blood pressure
- ☐ Low blood pressure
- ☐ Chronic congestive heart failure
- ☐ Heart Attack
- ☐ Heart disease
- ☐ phlebitis / varicose veins
- ☐ Stroke/ CVA
- ☐ Pacemaker or similar device

Is there a family history of any of the above?
☐No ☐Yes

Respiratory
- ☐ Chronic cough
- ☐ Shortness of breath
- ☐ Bronchitis
- ☐ Emphysema

Is there a family history of any of the above?
☐No ☐Yes

Arthritis
☐No ☐Yes_____
Is there a family history of arthritis?
☐No ☐Yes

Infections
- ☐ Hepatitis
- ☐ HIV
- ☐ Herpes
- ☐ Infectious skin conditions
- ☐ Infectious respiratory conditions

Allergy/ Hypersensitivity reactions
- ☐ Oil
- ☐ Temperature(hot/cold)
- ☐ Other_____
  _____

☐No ☐Yes
Type of reaction:

Head/Neck
- ☐ History of headaches
- ☐ History of migraines
- ☐ Vision problems
- ☐ Ear problems

Other Conditions
- ☐ Diabetes Type___
- ☐ Cancer
- ☐ Epilepsy
- ☐ Skin Conditions

Women
Pregnant, due: _____
Gynaecological conditions:
☐No ☐Yes
_____

Do you have any **other medical conditions**?(eg. Digestive conditions, haemophilia , osteoporosis, mental illness, etc.)
☐No
☐Yes_____
Do you have any internal **pins**, **wires**, **artificial joints** or **special equipment**?
☐No ☐Yes
If yes, what is that? _____
Where? _____

Are you currently receiving treatment from another health care professional? ☐No ☐Yes
If yes, for what? _____

Current Medication:_____
Condition it treats:_____

Overall, how is your general health?
☐Excellent ☐Good ☐Fair ☐Poor

Surgery Date:
Nature:_____
Injury Date:
Nature:_____

Primary Care Physician:_____
Address:_____
_____
_____

What is the **reason** you are seeking massage/acupuncture therapy? _____
Please include the **location** of any tissue or joint discomfort._____
Other discomfort: _____
_____

Note:

Date of initial Health History:_____
Update 1:_____
Update 2:_____
Update 3:_____
Update 4:_____

基本資料與病史表格

以下資料將可以保證治療的安全。如對下列問題有任何疑問可直接向我咨詢。除非法律要求，以下資料將會保密。如有他人要求下列資料需要先得到您的書面同意才能獲取。

名字:_____ 性別:___ 出生日期: (月)___(日)___(年)_____電話號碼:_____
地址:_____ 城市:_____郵政編碼:_____職業:_____
是否接受過按摩治療？ ☐有 ☐無
是否接受過針灸治療？ ☐有 ☐無
是否有其他醫護從業員建議接受按摩治療/針灸☐有 ☐無
如果有請提供名字與地址：_____
_____

如曾經有過或正有下列狀況請註明：

心血管
- ☐ 高血壓
- ☐ 低血壓
- ☐ 慢性心臟衰竭
- ☐ 心臟病發作
- ☐ 心臟病
- ☐ 靜脈炎/靜脈曲張
- ☐ 中風
- ☐ 起搏器或其他

是否有家族成員有過以上症狀
☐無 ☐是

呼吸道
- ☐ 咳嗽
- ☐ 氣促
- ☐ 支氣管炎
- ☐ 肺氣腫

是否有家族成員有過以上症狀
☐無 ☐有

關節炎
☐無 ☐有_____
是否有家族成員有過以上症狀
☐無 ☐有

感染
- ☐ 肝炎
- ☐ HIV
- ☐ 皰疹
- ☐ 皮膚感染
- ☐ 呼吸道感染

過敏或過敏性反應
- ☐ 油
- ☐ 溫度(熱/冷)
- ☐ 其它 _____ _____

☐無 ☐有
過敏反應類型：

頭/頸
- ☐ 頭痛
- ☐ 偏頭痛
- ☐ 眼部問題
- ☐ 耳部問題

其他
- ☐ 糖尿病 類型___
- ☐ 癌症
- ☐ 羊癲瘋
- ☐ 皮膚病

婦女
懷孕 預產期: _____
婦科問題：
☐無 ☐有
_____

有無**其它病症**?(例如：消化問題, 血友病 , 骨質疏鬆, 精神疾病, 等等)
☐無
☐有_____
體內有無 **釘, 線, 人造關節或者其它裝置**?
☐無 ☐有
如果有，那是什麼?_____
哪裡?_____

你現在有沒有正在接受其它醫護人員的治療? ☐無 ☐有
如果有，那是什麼?_____

正在使用的藥物：_____
為了治療什麼：_____

你的大概的健康狀況?
☐很好 ☐好 ☐一般 ☐較差

手術 日期:
什麼手術：_____
受傷 日期:
什麼傷：_____

家庭醫生：_____
地址：_____
_____
_____

您來接受按摩/針灸治療的**原因**：_____
哪裡的肌肉或關節不舒服：_____
其它不適：_____
_____

Note:

Date of initial Health History:_____
Update 1:_____
Update 2:_____
Update 3:_____
Update 4:_____