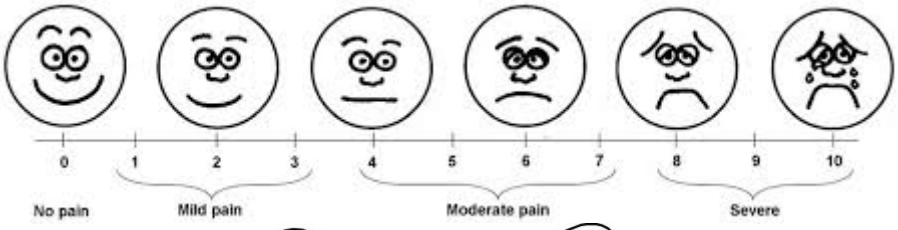
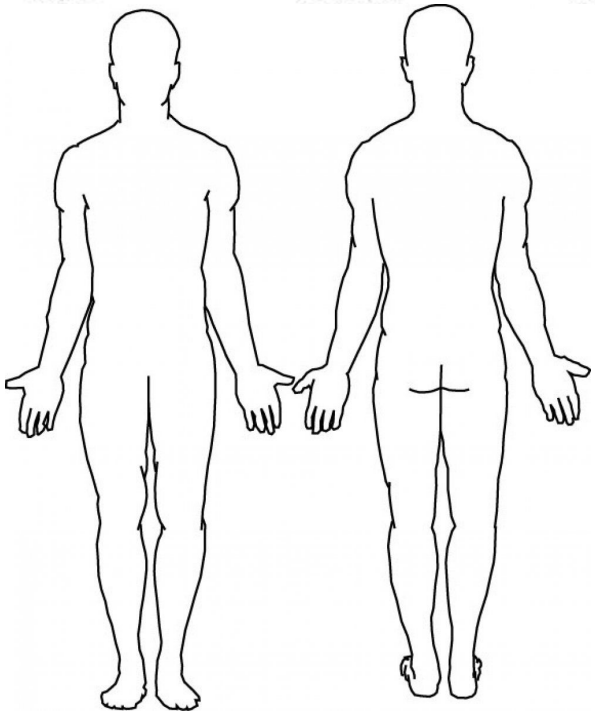
St. Amant Form & Wellness
Health History Form

An accurate health history is important to ensure that it is safe for you to receive a massage treatment. All information gathered for this treatment is confidential except as required or allowed by law. Written authorization will be required for release of any information. 24 hour cancellation notice is required otherwise a missed appointment fee will be charged. This form must be updated annually.

First Name:_____ Last Name: _____
Address:_____ Telephone:_____
City:_____Prov:_____ Email: _____
Postal Code:_____ Referenced by:_____
Do you have primary health care provider? _____
Emergency Contact Person and Telephone:_____
General Health Status: _____Primary Complaint:_____





Please see reverse side.

Please indicate if any of the following conditions are applicable to you, present or past.

Health History: Please indicate ☑ conditions you are experiencing, present or past.

Soft Tissue/Joints
(Specify its nature: Pain, Stiffness, Numbness, Twitching, etc.)

	Present	Past
❑ neck		
❑ shoulder		
❑ upper back		
❑ mid back		
❑ low back		
❑ arms		
❑ chest		
❑ legs		
❑ knees		
❑ hips		
❑ other		

History Headaches
- ❑ tension
- ❑ migraines
- ❑ tooth/jaw/ear pain
- ❑ head trauma/date: _____
- ❑ history of headaches/type: _____
- ❑ other: _____

Mental Health
- ❑ depression
- ❑ anxiety
- ❑ PTSD
- ❑ other (phobias, manic, etc.) _____
- ❑ family history of any of the above

Smoker: ❑

Respiratory
- ❑ chronic cough
- ❑ shortness of breath
- ❑ bronchitis
- ❑ asthma
- ❑ emphysema
- ❑ pneumonia
- ❑ sinus problems
- ❑ family history of any of the above

Cardiovascular
- ❑ high blood pressure
- ❑ low blood pressure
- ❑ heart attack (date:_____)
- ❑ phlebitis / DVT
- ❑ stroke / CVA (date:_____)
- ❑ pulmonary emboli
- ❑ pacemaker
- ❑ heart disease
- ❑ angina
- ❑ chronic congestive heart failure
- ❑ family history of any of the above

Infectious Disease
- ❑ hepatitis
- ❑ infections skin conditions
- ❑ tuberculosis
- ❑ HIV
- ❑ other: _____

Gastroinstestinal
- ❑ irritable bowel syndrome
- ❑ colitis
- ❑ gastroenteritis
- ❑ Crohn's disease
- ❑ constipation
- ❑ family history of any of the above

Skin
- ❑ skin condition
  specify _____
- ❑ bruise easily
- ❑ herpes
- ❑ varicose veins
- ❑ athletes foot
- ❑ loss of sensation

Other Conditions
- ❑ neurological conditions _____
- ❑ epilepsy
- ❑ diabetes/onset: _____
- ❑ allergies: _____
  (❑ anaphylaxis; ❑ skin irritations)
- ❑ family history of allergies
- ❑ family history of hypersensitivities
- ❑ cancer _____
- ❑ arthritis _____
  type OA/RA/other: _____
  where _____
- ❑ family history of arthritis
- ❑ vision loss
- ❑ hearing loss
- ❑ insomnia
- ❑ haemophilia
- ❑ kidney/bladder problems
  (❑ dialysis)
- ❑ overactive bladder
- ❑ osteopenia
- ❑ osteoporosis
- ❑ positional vertigo
- ❑ family history of any of the above
- ❑ other: _____

Please continue on the next page…

Women
- ❑ pregnant / due date: MM/DD/YY
- ❑ gynecological conditions: _____
- ❑ breast pain
  - o cysts
  - o breast lift (date): MM/DD/YY
  - o breast augmentation (date): MM/DD/YY
  - o breast reduction (date): MM/DD/YY
- ❑ menopause
- ❑ hysterectomy (date): MM/DD/YY

ACCIDENT/INJURY
❑ Car Accident ❑ Work Related ❑ Other
Date: _____
Symptoms: _____
_____
Physical Limitations: _____
_____
_____

Surgery
type _____
date: MM/DD/YY
current symptoms _____
_____
_____

Current Medications and Conditions
_____
_____
_____

❑ **Present involvement in other Health Care: Yes/No**
If Yes, specify: _____
❑ **Pins / Wires / Prosthetics:** _____
❑ **Medical Alert Bracelet** (specify condition / allergy)
_____
_____

I have read the above information and have stated all my previous and current medical conditions. I take it upon myself to update St. Amant Form & Wellness regarding any changes in my condition. I understand that all treatments will be discussed and planned with Michael St. Amant, and will require my informed consent. I understand the 24hour cancellation policy and agree to pay the missed appointment fee if I cancel within the 24hour period preceding my appointment time.

Signature: _____ Date:_____