**TRIMESTERS MASSAGE HEALTH HISTORY**

DATE:

NAME:

ADDRESS: POSTAL CODE:

PHONE NUMBER - Day: Evening:

EMAIL:

REFERRED BY:

Have you ever received massage in the past? Yes / no

Frequency of treatment:

Date of last treatment:

Current reason for seeking treatment:

Are you currently seeing any other type of practitioner (ie) Chiropractor, Physiotherapist, Acupuncturist?

Please list any medications or herbal remedies you are taking:

Please list any medical conditions, both current & past (ie) heart disease, asthma, high blood pressure, cancer, etc.:

Have you ever been in a motor vehicle accident? Yes / no

If possible, please give date(s) & treatment received:

If you have been pregnant in the past, please provide the following details:

Number of full term pregnancies:

Age of children:

Did you have any of the following? Please provide details as necessary.

An epidural

A C-section

Assisted delivery (ie) forceps, vacuum, episiotomy

Extended active labour (ie) over 8 – 12 hours

Prolonged second stage (pushing) (ie) over 2.5 hours

Did you receive any Pelvic Floor Physiotherapy following the birth of any of your children?

Please list any physical activity that you regularly participate in. (ie) Yoga, walking, running, weight training, spin, pilates, etc…

What is your current level of stress? (1 being low, 10 being very high)

What is your current energy level? (1 being low, 10 being high)

How many hours of sleep per night do you usually get?

Are you currently experiencing any sleep disturbances? Please explain.

Overall, are you satisfied with your current state of physical & mental health? If not, what would you like to change?

Please add anything else you would like me to know:

***Ladine Irving-Martin, Registered Massage Therapist 780-288-1629 www.trimestersmassage.com***