pure 91 wellness HEALTH HISTORY FORM

An accurate health history is important to ensure that it is safe for you to receive Massage Treatment, Acupuncture Treatments, and Personal Training. If your health status changes in the future, please let us know. All information gathered on this form is confidential. *Your written authorization is legally required before any of this information can be released.*

PATIENT NAME	DATE OF BIRTH (DD/MM/YYYY)

ADDRESS	CITY / TOWN	PROVINCE / STATE

POSTAL CODE	PHONE NUMBER	EMAIL ADDRESS

PLEASE INDICATE CONDITIONS YOU ARE EXPERIENCING OR HAVE EXPERIENCE

RESPIRATORY	
Chronic Cough	☐
Shortness of Breath	☐
Bronchitis	☐
Asthma	☐
Emphysema	☐

WOMEN	
Pregnant	☐
Breast Feeding	☐

HEAD & NECK	
Vision Problems	☐
Vision Loss	☐
Ear Problems	☐
Hearing Loss	☐

CARDIOVASCULAR	
High Blood Pressure	☐
Low Blood Pressure	☐
CCHF	☐
Heart Attack	☐
Phlebitis	☐
Stroke / CVA	☐
Pacemaker	☐

OTHER CONDITIONS	
Loss of Sensation	☐
Diabetes	☐
Allergies	☐
Epilepsy	☐
Cancer	☐
Arthritis	☐

AREAS OF CONCERN	
Neck	☐
Low Back	☐
Mid Back	☐
Upper Back	☐
Shoulders	☐
Arms	☐
Legs	☐
Knees	☐
Other	☐

INFECTIONS	
Hepatitis	☐
Skin Conditions	☐
TB	☐
HIV	☐

SURGICAL PROCEDURES

AREA	PROCEDURE	YEAR

CURRENT MEDICATIONS

MEDICATION NAME	START DATE	END DATE	PURPOSE