Update: _____
Update: _____
Update: _____
Update: _____

Patient Health History

Date of initial health history _____

The information requested 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 will be kept confidential unless allowed or required by law. Your written permission will be required to release any information.

Name _____
Address _____ City _____ Province _____ Postal Code _____
Home/cellular telephone _____ Email _____
Birth date _____ Occupation _____
Medical doctor name _____ Doctor's telephone _____
How did you hear about us? _____

Please indicate conditions you are experiencing or have experienced:

Cardiovascular
- ❑ High blood pressure
- ❑ Low blood pressure
- ❑ Chronic congestive heart failure
- ❑ Heart attack
- ❑ Phlebitis / varicose veins
- ❑ Stroke / CVA
- ❑ Pacemaker or similar device
- ❑ Heart disease
- ❑ Dizziness / vertigo
- ❑ Seizures

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

Respiratory
- ❑ Asthma
- ❑ Bronchitis
- ❑ Emphysema
- ❑ Chronic cough
- ❑ Shortness of breath

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

Digestive
- ❑ Constipation
- ❑ Crohn's Disease
- ❑ Colitis
- ❑ Irritable bowel syndrome
- ❑ Ulcers

Head and neck
- ❑ History of headaches
- ❑ History of migraine
- ❑ Vision problems
- ❑ Vision loss
- ❑ Ear problems
- ❑ Hearing loss

Muscle and joint
- ❑ Neck
- ❑ Lower back
- ❑ Mid-back
- ❑ Upper back
- ❑ Shoulders
- ❑ Elbow
- ❑ Wrist / Hand
- ❑ Hip
- ❑ Knee
- ❑ Ankle / feet
- ❑ Spine

Infections
- ❑ Hepatitis
- ❑ Skin conditions
- ❑ Tuberculosis
- ❑ HIV
- ❑ Herpes

Other
- ❑ Epilepsy
- ❑ Arthritis
- ❑ Allergies
- ❑ Hypersensitivity
- ❑ Shortness of breath

Women
- ❑ Pregnancy

Due date: _____

- ❑ Previous pregnancy complications

_____

_____

- ❑ Osteoporosis
- ❑ Scoliosis
- ❑ Chronic fatigue
- ❑ Fibromyalgia
- ❑ Hemophilia
- ❑ Polio / Post polio
- ❑ Loss of sensation

where: _____

- ❑ Diabetes

onset/type: _____

- ❑ Skin conditions

type/location: _____

- ❑ Menopausal problems

_____

- ❑ Menstrual problems

_____

- ❑ Gynecological conditions

_____

- ❑ Cancer

type/location:

_____

_____

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

Do you have any medical conditions not listed previously? ❑ Yes ❑ No
If yes, please describe: _____

_____

Do you have any internal wires, artificial joints, pacemakers, or special equipment of which we should be aware? ❑ Yes ❑ No

Please circle areas which are currently causing you symptoms of pain, stiffness, numbness, or other forms of discomfort:

face	upper back	arm(s)	hand(s)	thigh(s)	ankle(s)	neck
mid-back	elbow(s)	finger(s)	knee(s)	feet	shoulder	lower back
wrist(s)	hip(s)	leg(s)	toe(s)	chest	rib(s)	tailbone

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

Have you ever been invovled in any other motor vehicle accidents? ❑ Yes ❑ No
Have you ever been invovled in any other accidents? ❑ Yes ❑ No
Have you ever been knocked unconcious? ❑ Yes ❑ No

Briefly describe any surgeries you have undergone and when: _____

_____

Are you presently taking any medications? ❑ Yes ❑ No
If yes, please list the medication(s) and the condition(s) for which it is being used (if known):

_____

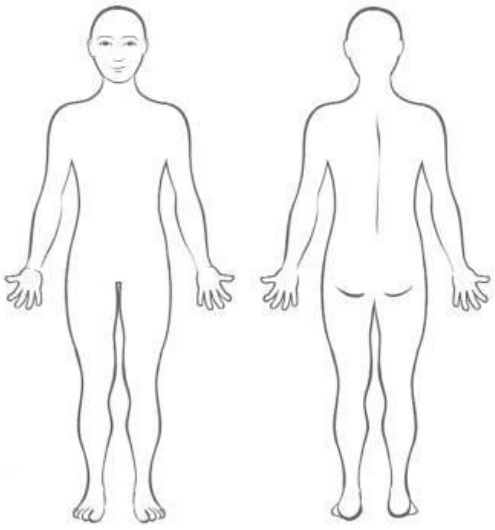
_____

Have you previously received massage therapy treatments: ❑ Yes ❑ No
If yes, were you treated: _____

_____

Please circle on the following scales the extent to which you are currently satisfied with the following:
(5 represents total satisfaction; 1 represents little or no satisfaction)

Physical health and fitness	5	4	3	2	1
Mental and emotional happiness	5	4	3	2	1
Energy level	5	4	3	2	1
Diet	5	4	3	2	1
Ability to relax	5	4	3	2	1



Please mark the areas of the body and/or list the reasons or conditions you are seeking treatment for today:

_____

_____

_____

_____

_____

_____

Massage Therapy Consent Form

Please take a moment to read and initial in agreeance with all of the following statements:

If I experience pain or discomfort during the session, I will immediately inform my therapist so that pressure/ strokes can be adjusted to my level of comfort. I will not hold my therapist responsible for any pain or discomfort I experience during or after the session.

_____

I understand that the services offered today are not a substitue for medical care. I understand that my therpist is not qualified to perform spinal or skeketal adjustments, to diagnose, to prescribe, or treat physical or mental illness.

_____

I affirm that I have notified my therapist of all known conditions and injuries.

_____

I agree to inform the therapist of any changes in my health and medical condition. I understand that there shall be no liability on the therapist's part should I forget to do so.

_____

I understand that massage is entirely therapeutic; the therpist will remain professional and maintain professional boundaries.

_____

I understand that should I cancel an appointment less than 24 hours before the shceduled time or not show for an appointment, I am subject to a fee equal to the cost of the missed appointment. If the appointment was booked under a gift certificate, it will be voided in lieu of the fee.

_____

Patient name _____ Signature of Patient _____
(or guardian)

Witness _____

Date _____