Confidential Health History

Please Print:

Name: _____ Date: _____

Address: _____ City: _____ Postal Code: _____

Phone #: (Home) _____ (Work) _____ Birthday: _____ Sex: ____

Height: _____ Weight: _____ Doctors Name: _____ Dr. Phone #: _____

E-mail address: _____ May we contact you via e-mail? Y N

When was your last physical check-up? _____

What is your occupation? _____

What are your recreational activities? _____

What brings you in for a massage? _____

Have you ever been to a massage therapist before? ❑ Yes ❑ No

Where did you hear about us? _____

Do you have extended health benefits/insurance that cover massage? ❑ Yes ❑ No

Have you ever been to a Chiropractor ❑ Yes ❑ No Physiotherapist ❑ Yes ❑ No

Other: _____

Please Check (✓) All That Apply To You:

GENERAL:

❑ left handed	❑ right handed	❑ glasses or contacts
❑ frequent colds	❑ earaches	
❑ medications - name & what for: _____		

CIRCULATION:

❑ anemia	❑ high blood pressure	❑ low blood pressure
❑ varicose veins	❑ diabetes - type _____	❑ heart disease
❑ ch. congestive heart failure	❑ dizziness - when: _____	❑ headaches - type: _____
❑ phlebitis	❑ leg cramping	❑ cancer - where: _____
❑ haemophilia	❑ stroke – when: _____	❑ myocardial infarction – when: _____

MUSCLES & JOINTS:

❑ arthritis - type: _____	❑ bursitis	❑ fracture(s) - where: _____
❑ neck pain	❑ whiplash - when: _____	❑ shoulder pain
❑ low back pain	❑ stiff joints	❑ swollen joints
❑ poor posture	❑ foot trouble	❑ TMJ problems
❑ fibromyalgia		

RESPIRATORY:

❑ chronic cough	❑ smoking - how much: _____	❑ emphysema
❑ asthma	❑ allergies - to what: _____	❑ bronchitis

over …

Please Check (✓) All That Apply To You:

INFECTIVE CONDITIONS:

❑ tuberculosis ❑ hepatitis ❑ HIV

SKIN:

❑ sensitive ❑ contagious rashes ❑ allergies to oils/creams
❑ eczema

DIGESTION:

❑ constipation ❑ diarrhea ❑ Crohns/Colitis
❑ diverticulitis ❑ ulcers ❑ nausea

NERVOUS:

❑ epilepsy ❑ sciatic pain ❑ pain/tingling/etc. - where: _____
❑ fatigue ❑ insomnia ❑ nerves/depression

WOMAN:

❑ pregnant - trimester: __ ❑ children - how many: _____ ❑ painful menstruation

SURGERY &/OR MAJOR INJURY:

Type:_____Date:_____

Current symptoms: _____

Do you have any pins/plates/artificial devices (pacemaker)? ❑ Yes ❑ No

If yes, what & where? _____

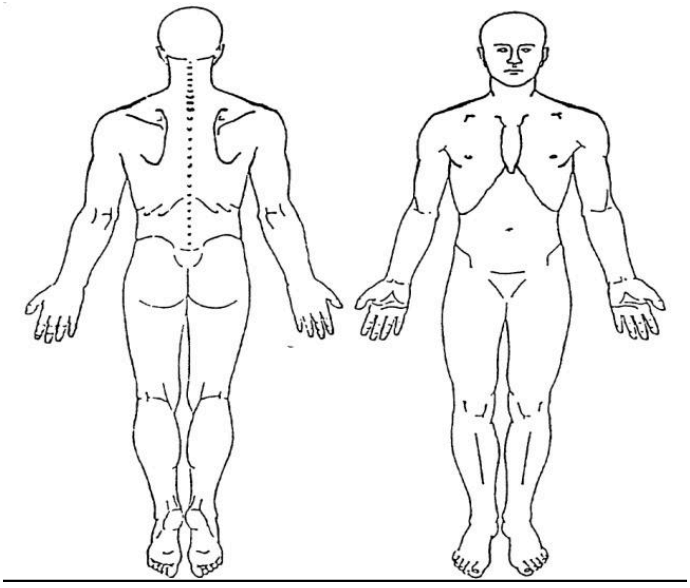
OTHER:

Is there anything that you have that has not been covered? Is there anything that you would like to expand on? If you need an additional sheet of paper, please ask.

_____

_____

_____



On the diagram, please indicate (circle) any areas of tension, discomfort, pain, tingling, stiffness and/or any area of concern that you would like addressed.

_____

_____

_____

_____

_____

_____

_____

_____

_____

Consent To Treatment

Please read and discuss any concerns with your therapist.

- The client can refuse treatment, alter treatment or terminate treatment *at any time.*
- Modalities to be used include: Swedish massage techniques, Trigger point therapy, Frictions, Hydrotherapy, and others as the therapist sees fit.
- Range of motion, Postural analysis, and Special tests may be performed.
- Draping procedure and positioning will be explained.
- Frequency and duration of treatments will be discussed.
- Clinic policies and fees will be explained.
- Prognosis will be given if possible.
- 24 hours notice is required if you need to cancel your appointment. Failure to do so will result in being charged full price for a missed appointment.
- Feedback by the client with regards to pressure, comfort, etc., and any questions the client may have are greatly appreciated by the therapist.

I recognize that my therapist and I are partners in my health care program and I agree to take responsibility for my health and lifestyle choices.

I understand that this form of therapy is not intended to replace the need for other appropriate professional health care for serious conditions.

Please note that all information provided on your health history will be kept confidentially unless allowed or required by law. Your written permission will be required to release any information.

I understand everything that has been explained and shown to me and I consent to treatment.

Signature: _____ Date: _____