Massage Therapy

Health History and Entrance Form

A complete health history helps us ensure it is safe to provide you with a massage treatment; please let us know if your status changes so we can update your form. All information given to us is confidential.

Name:_____ Email:_____
(We collect your email address to send you appointment reminders. Your email address will never be shared with a third party.)

Home Phone:_____Cell Phone:_____ Work Phone:_____.

Address: _____ Unit:_____ City:_____Prov.:_____ Postal Code:_____.

Date of Birth: (mm/dd/yyyy)_____ Age:_____ Occupation:_____.

How did you hear about us? _____

Do you have insurance coverage for massage? __Yes __No If yes, were you referred by your doctor __Yes __No

Doctor's Name:_____ Phone:_____ Last Check-Up Date:_____

Doctor's Street:_____Unit: _____ City:_____ Prov: _____ Postal Code:_____

Have you had a professional massage before? __Yes __No If yes, approximate date of last therapeutic massage_____

Do you see other healthcare practitioners? ___Chiro ___Physio ___Naturopath ___Osteopath ___Other

Current Medications:_____

Previous Major Illnesses/Operations (include dates)_____

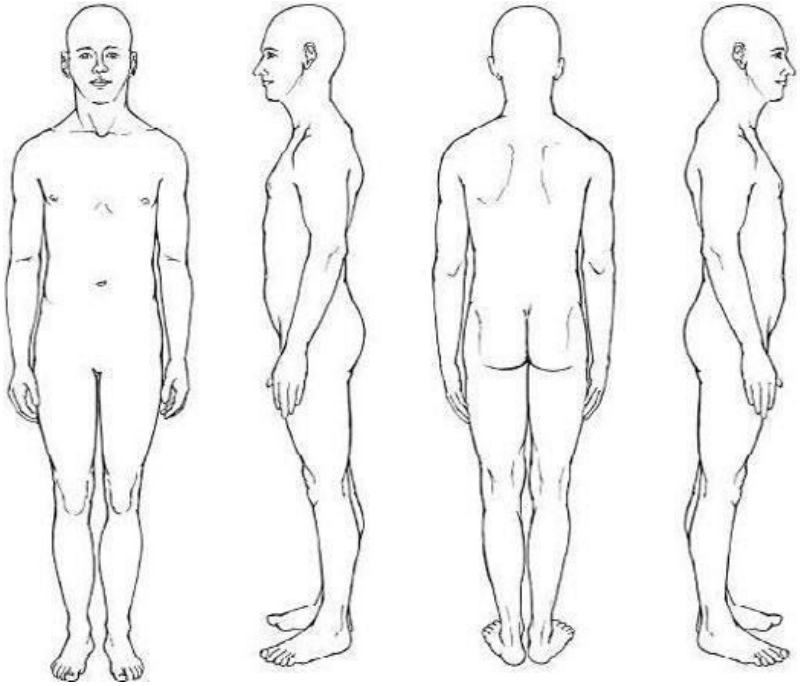
Allergies/Hypersensitivities:_____

Family History of:_____

Major Accidents (include dates)_____

Other Serious Medical Conditions:_____

Please Indicate areas you would like us to focus on and your primary area of complaint:



What is your Primary complaint?

_____

_____

_____

Health History and Entrance Form (please check all that apply to you)

General Symptoms

- ☐ Fainting / Dizziness
- ☐ Difficulty Sleeping / Fatigue
- ☐ Stress
- ☐ Headaches / Migraines
- ☐ Nervousness
- ☐ Numbness / Tingling; Where:_____
- ☐ Paralysis

Skin

- ☐ Rashes
- ☐ Excessive Dryness
- ☐ Acne
- ☐ Psoriasis
- ☐ Eczema
- ☐ Skin Cancer
- ☐ Bruise Easily

Infections

- ☐ Hepatitis
- ☐ Tuberculosis
- ☐ HIV / AIDS
- ☐ Herpes
- ☐ Athlete's Foot
- ☐ Warts

Respiratory

- ☐ Chronic Cough
- ☐ Bronchitis
- ☐ Asthma
- ☐ Shortness of Breath
- ☐ Emphysema
- ☐ Family History of _____

Lifestyle (check all that apply)

Regular Exercise	Yes	No	Mostly
Drink Plenty of Water	Yes	No	Mostly
8 Hours of Sleep nightly	Yes	No	Mostly
Good Eating Habits	Yes	No	Mostly

What is your general health?

_____

Joint / Muscle Discomfort

- ☐ Jaw
- ☐ Neck
- ☐ Shoulders
- ☐ Arms
- ☐ Hands
- ☐ Upper Back
- ☐ Mid Back
- ☐ Low Back
- ☐ Hips
- ☐ Legs
- ☐ Knees
- ☐ Feet
- ☐ Bursitis
- ☐ Arthritis
- ☐ Family History of Arthritis

Do You Have / Had?

- ☐ Diabetes Onset
- ☐ Cancer; Where _____
- ☐ Epilepsy
- ☐ Aneurysm / Stroke
- ☐ Neuromuscular Conditions
- ☐ Hypo / Hyper Glycaemic
- ☐ Depression
- ☐ Multiple Sclerosis
- ☐ Thyroid Problems

☐ Fibromyalgia

☐ Osteoporosis

☐ Mental Illness

☐ Artificial Implants / Pins / Plates;

Where _____

Male / Female

☐ Prostate

☐ Pregnant; Due Date _____

☐ Menstrual Cramping

☐ Menstrual Irregularity

☐ Birth Control

☐ Vaginal Pain / Infections

☐ Breast Pain / Lumps

☐ Menopausal

Cardiovascular

☐ High Blood Pressure

☐ Low Blood Pressure

☐ Heart Attack / Disease

☐ Congestive Heart Failure

☐ Stroke / Aneurysm

☐ Heart Murmur

☐ Pacemaker

☐ High Cholesterol

☐ Swelling of Ankles

☐ Cold Hands / Feet

☐ Poor Circulation

☐ Feet

☐ Varicose Veins / Phlebitis

☐ Family History of _____

Gastrointestinal

☐ Poor / Excessive Appetite

☐ Excessive Thirst

☐ Gas / Bloating

☐ Colitis

☐ Crohn's

☐ Constipation

☐ Diarrhea

☐ Nausea / Vomiting

☐ Ulcer

☐ Abdominal Cramps

☐ Gall Bladder Problems

☐ Liver Problems

EENT

☐ Vision Problems

☐ Dental Problems

☐ Sore Throat

☐ Ear Aches

☐ Hearing Difficulty

☐ Hearing Aid

☐ Stuffed Nose / Sinus

☐ Allergies / Hypersensitivity to _____

Type of Reaction _____

☐ Swollen Glands

Please read and sign:

- I attest that the information I have provided is true and complete to the best of my knowledge.
- I understand the information I have provided on this form is confidential and will not be released without my written consent.
- I understand that the therapist can end treatment at anytime due to inappropriate behaviour.
- I consent to a health assessment/reassessments and therapeutic massage treatment at Massage Addict.
- I authorize Massage Addict to contact my doctor or other health care professional listed above if required for treatment purposes.
- I understand that all sessions include a pre-health assessment and change time.
- I understand 24 hours notice is required to reschedule all future appointments, or full charges will apply.
- I authorize my health file to be transferred to another Massage Addict clinic if I relocate or a new Massage Addict clinic opens closer to my household.

Signature _____ Today's Date _____