Health History and Entrance Form

A complete health history helps us ensure it is safe to receive a massage treatment; please let us know if your status changes so we can update your forms. 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.

Do we have your permission to also send you our: ___Newsletters ____ Promotional Offers

Home Phone _____ **Cell Phone** _____ **Work Phone** _____

Street _____ **Unit #**_____ **City** _____ **Province** ____ **Postal Code** _____

Date of Birth _____ **Age** _____ **Occupation** _____

How did you hear about us? _____

Doctor _____ **Phone** _____ **Last Check-up Date** _____

Do you have insurance coverage for massage? □ Yes □ No **If yes, were you referred by your doctor?** □ Yes □ No

Have you had a professional massage before? □ Yes □ No **Approx. date of last therapeutic massage** _____

Do you see other healthcare practitioners? □ Chiro □ Physio □ Naturopath □ Osteopath Other _____

Current Medications _____

Previous Major Illnesses/Operations (provide dates) _____

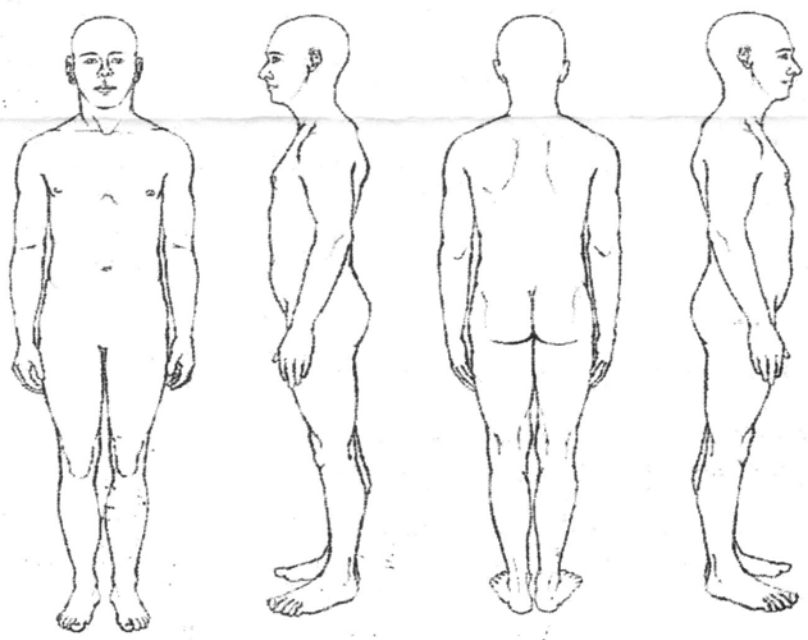
Major Accidents (provide dates) _____

Other Serious Medical Conditions _____

Family History of _____

Allergies/Hypersensitivities _____

Please indicate areas you would like us to focus on



Over →

Please check any that apply to you

General Symptoms
- ☐ Fainting / Dizziness
- ☐ Difficulty Sleeping / Fatigue
- ☐ Stress
- ☐ Headaches / Migraines
- ☐ Nervousness
- ☐ Numbness / Tingling
- ☐ Paralysis

Do you have / had?
- ☐ Diabetes
- ☐ Cancer
- ☐ Epilepsy
- ☐ Aneurysm/Stroke
- ☐ Neuromuscular conditions
- ☐ Hypo/Hyper glycaemic
- ☐ Depression
- ☐ Multiple Sclerosis
- ☐ Thyroid Problems
- ☐ Fibromyalgia
- ☐ Osteoporosis
- ☐ Mental Illness
- ☐ Artificial implants/pins/plates
  Where_____

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

Male / Female
- ☐ Prostate
- ☐ Pregnant; Due Date _____
- ☐ Menstrual Cramping
- ☐ Menstrual Irregularity
- ☐ Birth Control
- ☐ Vaginal Pain / Infections
- ☐ Breast Pain / Lumps
- ☐ Menopausal

Joint/Muscle Discomfort
- ☐ Jaw
- ☐ Neck
- ☐ Shoulders
- ☐ Arms
- ☐ Hands
- ☐ Upper Back
- ☐ Mid Back
- ☐ Low Back
- ☐ Hips
- ☐ Legs
- ☐ Knees
- ☐ Feet
- ☐ Bursitis
- ☐ Arthritis
- ☐ Family history of Arthritis

EENT
- ☐ Vision Problems
- ☐ Dental Problems
- ☐ Sore Throat
- ☐ Ear Aches
- ☐ Hearing Difficulty
- ☐ Hearing Aid
- ☐ Stuffed Nose / Sinus
- ☐ Allergies
- ☐ Swollen Glands

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

Cardiovascular
- ☐ High Blood Pressure
- ☐ Low Blood Pressure
- ☐ Heart Attack/Disease
- ☐ Congestive Heart Failure
- ☐ Stroke/Aneurism
- ☐ Heart Murmur
- ☐ Pacemaker
- ☐ High Cholesterol
- ☐ Swelling of Ankles
- ☐ Cold Hands or Feet
- ☐ Poor Circulation
- ☐ Varicose Veins/Phlebitis

Family History of _____

Gastro-Intestinal
- ☐ Poor/ Excessive Appetite
- ☐ Excessive Thirst
- ☐ Gas/Bloating
- ☐ Colitis
- ☐ Crohn's
- ☐ Constipation
- ☐ Diarrhea
- ☐ Nausea/Vomiting
- ☐ Ulcer
- ☐ Abdominal Cramps
- ☐ Gall Bladder Problems
- ☐ Liver Problems

Respiratory
- ☐ Chronic Cough
- ☐ Bronchitis
- ☐ Asthma
- ☐ Shortness of Breath
- ☐ Emphysema

Family History of _____

Lifestyle

☐ Yes	☐ No	☐ Some	Regular exercise
☐ Yes	☐ No	☐ Some	Drink plenty of water
☐ Yes	☐ No	☐ Mostly	8 hours of sleep nightly
☐ Yes	☐ No	☐ Mostly	Good eating habits

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
- I authorize Massage Therapist 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.

Signature_____ Today's Date _____

Please note any future updates to this form by writing the date beside the change and asking the client to initial it