

**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 \_\_\_\_\_

Street \_\_\_\_\_ Unit \_\_\_\_\_ City \_\_\_\_\_ Prov. \_\_\_\_\_ Postal Code \_\_\_\_\_

Date of Birth (MM-DD-YY) \_\_\_\_\_ Age \_\_\_\_\_ Gender \_\_\_\_\_ 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 \_\_\_\_\_

Were you referred by another health care practitioner? If yes, who \_\_\_\_\_

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 \_\_\_\_\_

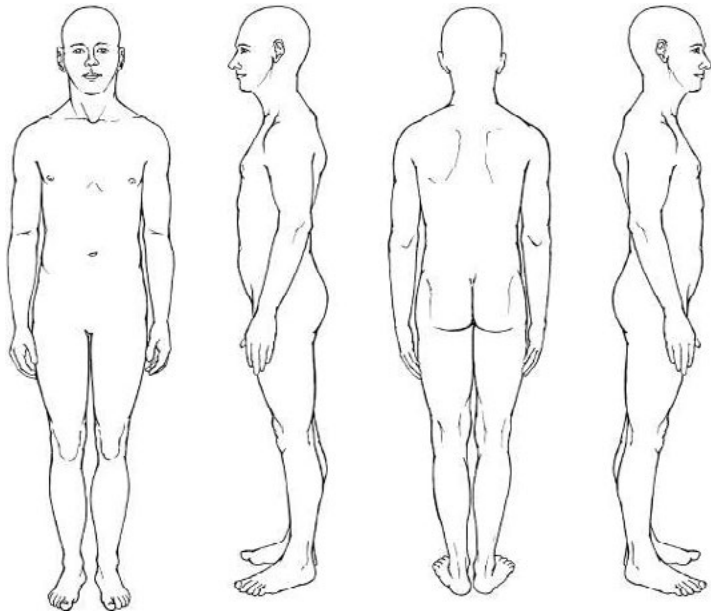
Current Medications and Conditions Treating \_\_\_\_\_

Previous Major Illnesses/Operations (include dates) \_\_\_\_\_

Major Accidents \_\_\_\_\_

**Please indicate areas you would like us to focus on and your primary area of complaint.**

**What is your primary complaint?**



\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

## Massage

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

#### Respiratory

- Chronic cough
- Bronchitis
- Asthma
- Shortness of breath
- Emphysema
- Family history any of the above

#### Joint/Muscle

- Jaw
- Neck
- Shoulders
- Arms
- Hands
- Upper back
- Mid back
- Low back
- Hips
- Knees
- Feet

#### 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?

\_\_\_\_\_

\_\_\_\_\_

#### Cardiovascular

- High blood pressure
- Low blood pressure
- Heart attack/disease
- Congestive heart failure
- Stroke/aneurysm
- Pacemaker
- Varicose veins/phlebitis
- Family history any of above

#### Other

- Arthritis OA/RA
- Headaches/migraines
- Loss of sensation/numbness/tingling
- Diabetes, onset \_\_\_\_\_
- Cancer, where \_\_\_\_\_
- Epilepsy
- Haemophilia
- Neuromuscular conditions
- Osteoporosis
- Mental illness
- Family history of any of above
- Artificial implants / pins / plates;  
where \_\_\_\_\_

#### Infections

- Hepatitis
- Tuberculosis
- HIV/AIDS
- Herpes
- Skin conditions  
what \_\_\_\_\_

#### EENT

- Vision loss/problems
- Dental problems
- Hearing loss/ear problems
- Hearing aid
- Sinus problems
- Allergies/hypersensitivity to  
type of reaction \_\_\_\_\_

#### Reproductive

- Prostate problems
- Pregnant, due \_\_\_\_\_
- Gynaecological conditions  
\_\_\_\_\_

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 \_\_\_\_\_

Date updated \_\_\_\_\_ Client initial \_\_\_\_\_ Date updated \_\_\_\_\_ Client initial \_\_\_\_\_

Date updated \_\_\_\_\_ Client initial \_\_\_\_\_ Date updated \_\_\_\_\_ Client initial \_\_\_\_\_