MASSOTHÉRAPIE
Massage Addict

Reflexology

Health History and Entrance Form

A complete health history helps us ensure it is safe to provide you with a reflexology 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 _____ Occupation _____

How did you hear about us? _____

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

Have you had a reflexology treatment before? ☐ Yes ☐ No If yes, approximate date of last reflexology treatment _____

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

Current Medications _____

Previous Major Illnesses/Operations (include dates) _____

Allergies/Hypersensitivities _____

Major Accidents (include dates) _____

Other Serious Medical Conditions _____

What brings you in today?

_____

_____

_____

_____

_____

_____

MASSOTHÉRAPIE
Massage Addict

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

General Symptoms

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

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;
Type _____

Do You Have / Had?

☐ Diabetes Onset _____
☐ Cancer; Type _____
☐ 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
☐ Menstrual Cramping
☐ Menstrual Irregularity
☐ Birth Control
☐ Vaginal Pain / Infections
☐ Breast Pain / Lumps
☐ Menopausal
☐ Endometriosis
☐ Pregnant; Trimester _____

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 Reflexologist can end treatment at anytime due to inappropriate behaviour.
- I give the consent to a Reflexology session.
- Please be aware that the Certified Reflexologist does not diagnose, prescribe or treat for specific conditions. Reflexology is not a substitute for a medical treatment, but is a compliment to most types of therapy.
- 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 Massaothérapie Massage Addict clinic if I relocate or a new Massage Addict clinic opens close to my household.

Signature _____ Today's Date _____