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:_____

Your email address will never be shared with a third party.

Home Phone:_____ Cell Phone:_____

Street:_____ Unit:_____ City:_____ Postal Code:_____

Date of Birth (MM-DD-YY):_____ Occupation:_____

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

Doctor's Address: Street:_____City:_____

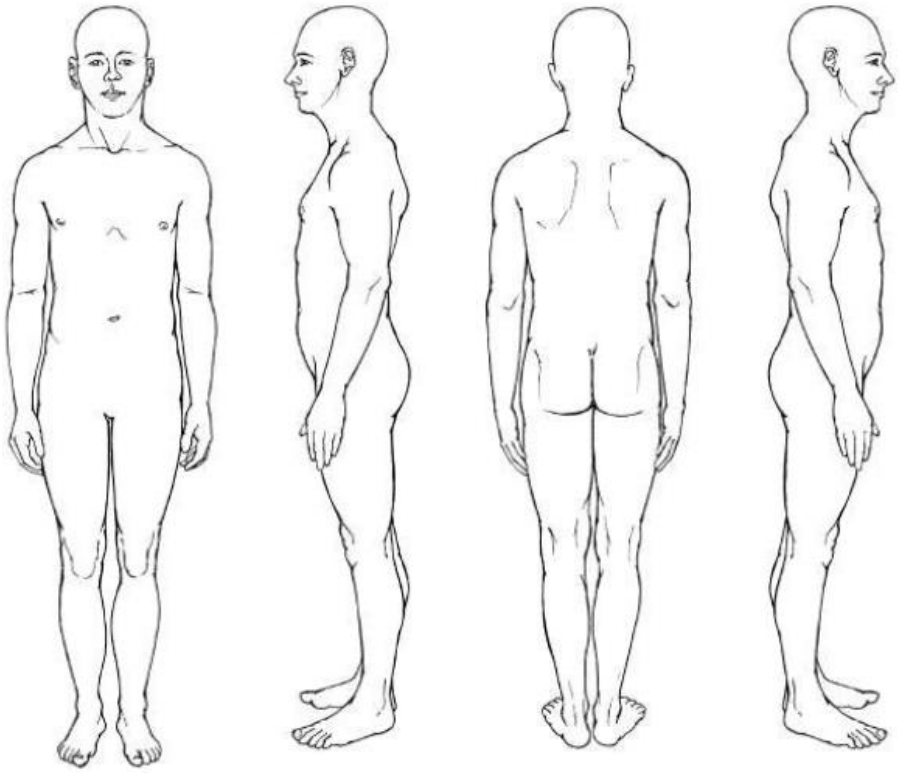
Have you had a professional massage before? Yes No

Do you see other healthcare practitioners? Chiro Physio Naturopath Osteopath

Other:_____

How is your overall health?_____

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



What is your primary complaint?

_____

_____

_____

Please Check All That Apply

General Symptoms:

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

Skin:

- ☐ Rashes
- ☐ Psoriasis
- ☐ Eczema
- ☐ Bruise Easily

Infections:

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

Respiratory:

- ☐ Chronic Cough
- ☐ Bronchitis
- ☐ Asthma
- ☐ Emphysema
- ☐ Family History of:_____

Joint/Muscular:

- ☐ Bursitis
- ☐ Arthritis
- ☐ Swelling
  Where_____
- ☐ Artificial Joints
  Where:_____
- ☐ Osteoporosis
- ☐ Fibromyalgia

Do you Have/Have You Had:

- ☐ Diabetes
- ☐ Cancer
  Type:_____
  Onset:_____
  Current Stage:_____
- ☐ Epilepsy
- ☐ Aneurysm/stoke
- ☐ Hypo/hyper glycaemia
- ☐ Depression
- ☐ MS
- ☐ Thyroid Problems
- ☐ Mental Illness

Cardiovascular:

- ☐ High Blood Pressure
- ☐ Low Blood Pressure
- ☐ Heart Attack / Disease
- ☐ Congestive Heart Failure
- ☐ Heart Murmur
- ☐ Pacemaker
- ☐ High Cholesterol
- ☐ Varicose Veins / Phlebitis
- ☐ Family History of:_____

Gastrointestinal:

- ☐ Crohn's/Colitis
- ☐ Ulcers
- ☐ Gall Bladder Problems
- ☐ Liver Problems

EENT:

- ☐ Vision Problems
- ☐ Dental Problems
- ☐ Hearing Difficulty
- ☐ Hearing Aid
- ☐ Allergies / Hypersensitivity
  To:_____
  Type of Reaction:_____

Lifestyle (circle what best describes you)

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

Current Medications/Vitamins/Supplements:_____

_____

Previous Major Illnesses/Operations/Accidents (include dates):_____

_____

Family History of:_____

Other Serious Medical Conditions:_____

Please Read and Sign

I confirm the information on this form is correct to the best of my knowledge and will inform my therapist should anything change. I understand the therapist has the right to end any treatment due to inappropriate behaviour. I consent to the massage treatment plan set forth by my massage therapist. I recognize that a cancellation policy exists and it can be used at the discretion of the therapist.

Signature:_____Date:_____