

**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 _____

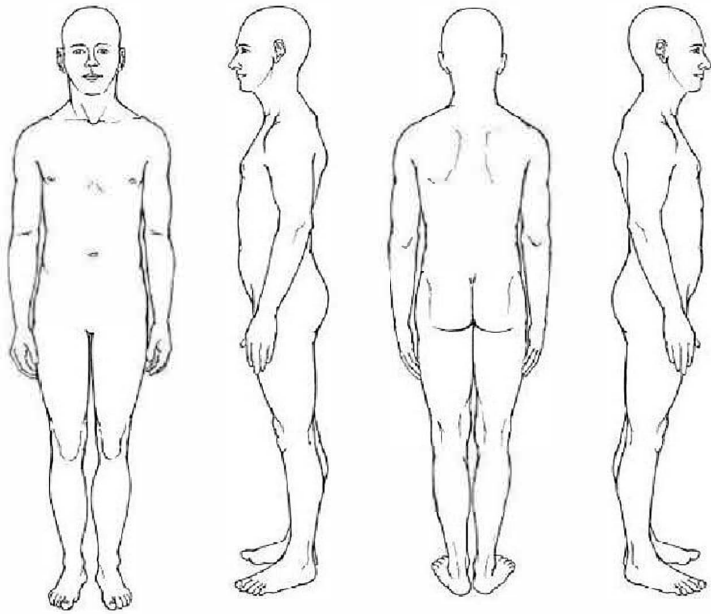
Current Medications and Conditions Treating _____

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 Human Strategies.
- I authorize Human Strategies 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 _____

Date updated _____

Client initial _____

Date updated _____

Client initial _____

Date updated _____

Client initial _____

Date updated _____

Client initial _____