

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

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 \_\_\_\_\_

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

Allergies/Hypersensitivities \_\_\_\_\_

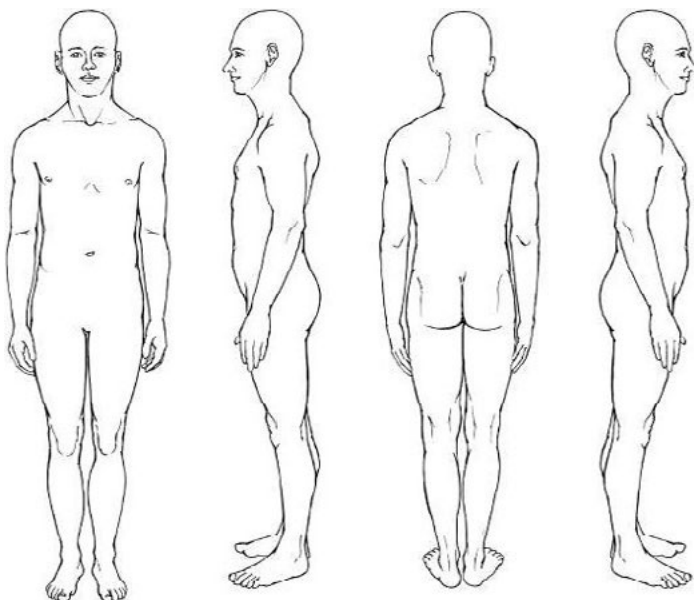
Family History of \_\_\_\_\_

Major Accidents (include dates) \_\_\_\_\_

Other Serious Medical Conditions \_\_\_\_\_

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

**What is your primary complaint?**



\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

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

**General Symptoms**

- Fainting / Dizziness
- Difficulty Sleeping / Fatigue
- Stress
- Headaches / Migraines
- Nervousness
- Numbness / Tingling; Where: \_\_\_\_\_
- Paralysis

**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

**Do You Have / Had?**

- Diabetes Onset \_\_\_\_\_
- Cancer; Where \_\_\_\_\_
- 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
- Pregnant; Due Date \_\_\_\_\_
- Menstrual Cramping
- Menstrual Irregularity
- Birth Control
- Vaginal Pain / Infections
- Breast Pain / Lumps
- Menopausal

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