Massage Addict

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 _____

Emergency Contact Name _____ Emergency Contact Phone _____

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 _____

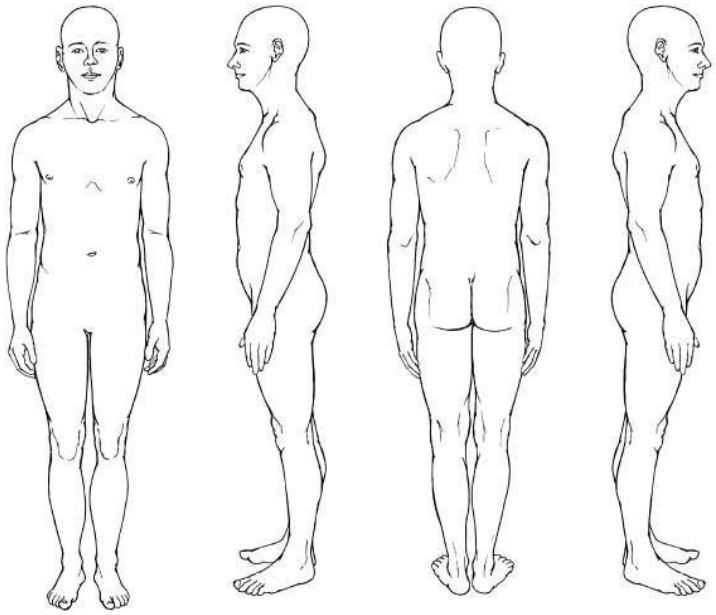
Do you see other healthcare practitioners? ☐ Chiro ☐ Physio ☐ Naturopath ☐ Osteopath ☐ Other _____

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?

_____

_____

_____

_____

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Massage
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Respiratory
- ☐ Chronic cough
- ☐ Bronchitis
- ☐ Asthma
- ☐ Shortness of breath
- ☐ Emphysema

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

Other
- ☐ Fever
- ☐ Arthritis OA/RA
- ☐ Headaches/migraines
- ☐ Loss of sensation/numbness/tingling
- ☐ Diabetes, onset _____
- ☐ Cancer, where _____
- ☐ Epilepsy
- ☐ Haemophilia
- ☐ Neuromuscular conditions
- ☐ Osteoporosis
- ☐ Mental illness
- ☐ Skin conditions
  what _____
- ☐ Artificial implants / pins / plates;
  where _____

EENT
- ☐ Vision loss/problems
- ☐ Dental problems
- ☐ Hearing loss/ear problems
- ☐ Hearing aid
- ☐ Sinus problems
- ☐ Allergies/hypersensitivity to
  type of reaction _____

Reproductive
- ☐ Pregnant, due _____

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 _____