Massage Addict

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) _____

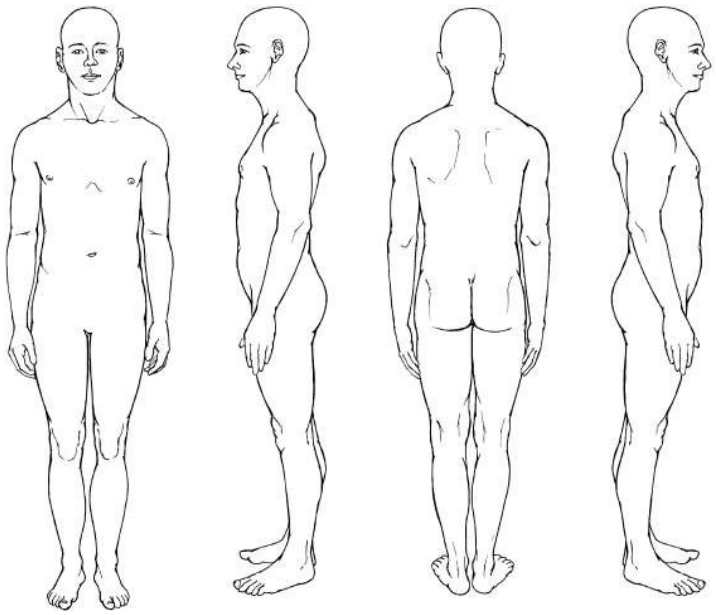
Allergies/Hypersensitivities _____

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?

_____

_____

_____

_____

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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 _____