

Health History and Entrance Form

A complete health history helps us ensure it is safe to receive a massage treatment; please let us know if your status changes so we can update your forms. All information given to us is confidential.

Name _____ Email _____

Home Phone _____ Cell Phone _____ Work Phone _____

Street _____ Unit # _____ City _____ Province _____ Postal Code _____

Date of Birth _____ Age _____ Occupation _____

How did you hear about us? _____

Doctor _____ Phone _____ Last Check-up Date _____

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

Have you had a professional massage before? Yes No Approx. date of last therapeutic massage _____

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

Current Medications _____

Previous Major Illnesses/Operations (provide dates) _____

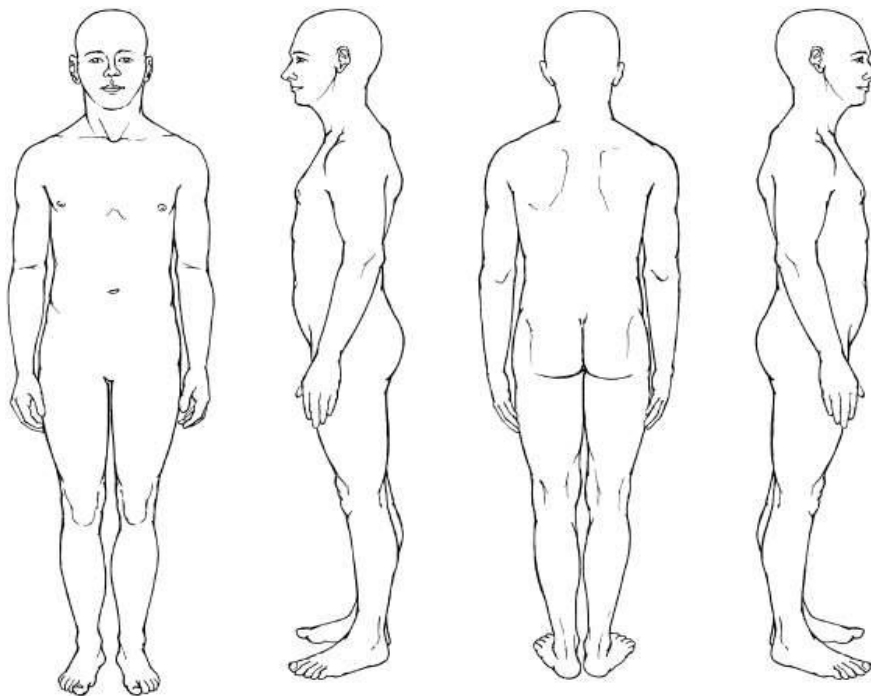
Major Accidents (provide dates) _____

Other Serious Medical Conditions _____

Family History of _____

Allergies/Hypersensitivities _____

Please indicate areas of soft tissue or joint discomfort



Over →

Please check any that apply to you

General Symptoms

- Fainting / Dizziness
- Difficulty Sleeping / Fatigue
- Stress
- Headaches / Migraines
- Nervousness
- Numbness / Tingling
- Paralysis

Do you have / had?

- Diabetes
- Cancer
- Epilepsy
- Aneurysm/Stroke
- Neuromuscular conditions
- Hypo/Hyper glycaemic
- Depression
- Multiple Sclerosis
- Thyroid Problems
- Fibromyalgia
- Osteoporosis
- Mental Illness
- Artificial implants/pins/plates
Where _____

Infections

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

Male / Female

- Prostate
- Pregnant; Due Date _____
- Menstrual Cramping
- Menstrual Irregularity
- Birth Control
- Vaginal Pain / Infections
- Breast Pain / Lumps
- Menopausal

Joint/Muscle Discomfort

- Jaw
- Neck
- Shoulders
- Arms
- Hands
- Upper Back
- Mid Back
- Low Back
- Hips
- Legs
- Knees
- Feet
- Bursitis
- Arthritis
- Family history of Arthritis

EENT

- Vision Problems
- Dental Problems
- Sore Throat
- Ear Aches
- Hearing Difficulty
- Hearing Aid
- Stuffed Nose / Sinus
- Allergies
- Swollen Glands

Skin

- Rashes
- Excessive Dryness
- Acne
- Psoriasis
- Eczema
- Skin Cancer
- Bruise Easily

Lifestyle

- Yes No Some
- Yes No Some
- Yes No Mostly
- Yes No Mostly

Cardiovascular

- High Blood Pressure
- Low Blood Pressure
- Heart Attack/Disease
- Congestive Heart Failure
- Stroke/Aneurism
- Heart Murmur
- Pacemaker
- High Cholesterol
- Swelling of Ankles
- Cold Hands or Feet
- Poor Circulation
- Varicose Veins/Phlebitis
- Family History of _____

Gastro-Intestinal

- Poor/ Excessive Appetite
- Excessive Thirst
- Gas/Bloating
- Colitis
- Crohn's
- Constipation
- Diarrhea
- Nausea/Vomiting
- Ulcer
- Abdominal Cramps
- Gall Bladder Problems
- Liver Problems

Respiratory

- Chronic Cough
- Bronchitis
- Asthma
- Shortness of Breath
- Emphysema
- Family History of _____

- Regular exercise
- Drink plenty of water
- 8 hours of sleep nightly
- Good eating habits

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.

Signature _____

Today's Date _____

Please note any future updates to this form by writing the date beside the change and asking the client to initial it.