HEALTH HISTORY

All information is confidential and used for the sole purpose of determining treatment protocols. Information will only be released to health care professionals or legal representatives with your written permission.

Name____

Address____

City__________________________Province________________Postal Code____________________

Contact phone_________________________Email____

Date of Birth____________________Weight_____________Blood Pressure_____________________

M.D._________________________________Name of Insurance Company______________________

Have you received massage therapy before?_________Response (positive or negative)_____________

Are you currently receiving treatment from any other health care practitioner (ND, physiotherapist, chiropractor, osteopath etc)?____

Have you received or are familiar with Matrix Repatterning or energetic techniques?_______________

Please list any significant (recent or older) car accidents, major surgeries, falls, concussions or injuries. Include dates, resulting physical limitations and current symptoms:______________________________

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Do you have any known allergies or hypersensitive reactions?_________________________________

What ***current condition*** are you receiving medications for?__________________________________

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Are there areas that you do NOT wish to have treated and reasons why.__________________________

PLEASE CIRCLE ALL CONDITIONS CURRENTLY BEING EXPERIENCED

MUSCLES/JOINTS/NERVE

Tension/Migraine headaches
Arthritis – OA/RA
Dislocations/Frozen shoulder
Carpal Tunnel/TMJ syndrome
Tendonitis/Bursitis
Scoliosis
Multiple Sclerosis
Sprains/Strains
Concussion Syndrome

SKIN

Athlete's foot/Plantar warts
Open sores/cuts/rashes
Contagious skin disease

VISION

Cataracts/Eye surgery
Contact lenses

HEART/CIRCULATORY

High/Low Blood Pressure
Heart Attack/Stroke/TIA
Diabetes
Vericose veins/Phlebitis
Reynauds Disease
Hemophilia

DIGESTION

Constipation
Diarrhea
Ulcers

GENITOURINARY

Kidney disease
Bladder dysfunction
Gynecological surgery
Pregnancy – Due Date:
____

LUNG/RESPIRATION

Asthma/Bronchitis
Pneumonia
Sinus problems
Tuberculosis
HIV/AIDS

OTHER

Cancer
Chronic Fatigue
Hyper/Hypo Thyroid
Insomnia
Pacemaker
Hearing Loss
Prosthesis
Pins/Wires/Plates/Rods
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INFORMED CONSENT

Massage Therapy is a holistic approach to maintaining a healty lifestyle. I understand and am informed that as in all health care, there are some risks to the treatment including but not limited to muscle tenderness headaches and possibly an increase in presenting symptoms. I expect the therapist will exercise judgment during the course of treatment and which the therapist feels at the time are based on facts then known.

I hereby request and consent to treatment:

Client Name (please print)____

Client Signature ____

Date ____