Chart #_____
Date_____

MASSAGE CLIENT HEALTH HISTORY

Last Name_____ First Name_____ □ Male □ Female

Address_____ City_____ Province _____

Postal Code_____ Home Phone_____ Cell Phone_____

Birth Date (DD/MM/YYYY)_____ Occupation_____

May we contact you via e-mail? All contact information is kept confidential and we only send about 1 e-mail/month.

□ Yes, e-mail address_____ □ No, thanks.

How did you hear about us?_____

Please indicate conditions you are experiencing or have experienced:

Cardiovascular

- ☐ High blood pressure
- ☐ Low blood pressure
- ☐ Chronic congestive heart failure
- ☐ Heart attack
- ☐ Phlebitis/varicose veins
- ☐ Stroke/CVA
- ☐ Pacemaker or similar device
- ☐ Heart disease
- ☐ Dizziness/vertigo
- ☐ Seizures

Muscle/Joint

- ☐ Neck
- ☐ Back (lower)
- ☐ Back (mid)
- ☐ Back (upper)
- ☐ Shoulders
- ☐ Elbow
- ☐ Wrist/hand
- ☐ Hip
- ☐ Knee
- ☐ Ankle/foot
- ☐ Spine

Skin Conditions

- ☐ Eczema
- ☐ Psoriasis
- ☐ Rash
- ☐ Warts
- ☐ Open sores

Respiratory

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

Head and Neck

- ☐ History of headaches
- ☐ History of migraines
- ☐ Vision problems
- ☐ Vision loss
- ☐ Ear problems
- ☐ Hearing loss

Other

- ☐ Epilepsy
- ☐ Arthritis
- ☐ Hemophilia
- ☐ Fibromyalgia
- ☐ Chronic fatigue
- ☐ Scoliosis
- ☐ Polio/post-Polio
- ☐ Osteoporosis
- ☐ Loss of sensation
  Where?_____
- ☐ Diabetes
  Onset:_____
  Type:_____
- ☐ Cancer
  Type:_____

Infectious Conditions

- ☐ Skin conditions
  Describe:_____
  _____
  _____
- ☐ Respiratory conditions
  Describe:_____
  _____
  _____
- ☐ Hepatitis
- ☐ HIV

Women

- ☐ Pregnancy
  Due date:_____
- ☐ Previous pregnancy complications
  _____
  _____
  _____

Chart #_____
Date_____

Do you have any medical conditions not listed above? ☐ Yes ☐ No

If yes, please describe: _____

Do you have any internal wires, artificial joints, pacemakers or special equipment that we should be aware of?
☐ Yes ☐ No

For what condition are you seeking treatment today? _____

Have you seen any other health care professional(s) for this condition or reason? ☐ Yes ☐ No
If yes, what types of treatment have you received (e.g. chiropractic, physiotherapy, acupuncture, etc.)?

_____

Have you ever been involved in any motor vehicle accidents? ☐ Yes ☐ No Date:_____
Have you been involved in any other accidents? ☐ Yes ☐ No Date:_____
Have you ever been knocked unconscious? ☐ Yes ☐ No Date:_____

Briefly list any surgeries you have undergone, for what and when:

_____

_____

Are you presently taking any prescribed medication(s)?
If yes, please list the medication(s) and the conditions for which it is being used if known:

_____

_____

Have you previously received massage therapy treatments? ☐ Yes ☐ No
If yes, where were you treated and by whom? _____

I acknowledge that the Massage Therapist is not a physician and does not diagnose illness or disease or any other physical or mental disorder. I clearly understand that massage therapy is not a substitute for a medical examination. It is recommended that I attend my personal physician for any ailment that I may be experiencing. I acknowledge that no assurance or guarantee has been provided to me as to the results of the treatment.
I acknowledge and understand that the Massage Therapist must be fully aware of my existing medical conditions. I have completed my medical history form as provided by my Massage Therapist and disclosed all of those medical conditions affecting me. It is my responsibility to keep the Massage Therapist updated on my medical history. The information I have provided is true and complete to the best of my knowledge.

_____ _____ _____
Signature Date Therapist Signature

Note: 24-Hour Notice for Cancellation of Massage Appointments
I understand I will incur and be responsible for a fee of $30.00 for same-day cancellations or missed appointments.

Initial here: _____