

Massage Health History Form

The information requested below will assist us in treating you safely. Please feel free to ask any questions about the information that we require. Please note that all information provided below will be kept confidentially unless allowed or required by law. Your written permission will be required to release any information. If your health status changes in the future, please let us know.

Emergency Contact Name:

Phone #: (

Name:

Phone #: (

)

Address Street: Town: Postal Code: Province: Email:		Have you received massage therapy before? Yes □ No □ Did a health care practitioner refer you? Yes □ No □ If Yes, Name: If No, who referred you? Name and address of family physician:	
Occupation:		Date of Birth:// M D Y	
Please indica	te conditions you are expe	encing or have experienced in the past	
Cardiovascular High blood pressure Chronic congestive heart failure Irregular heart beat Heart attack Pacemaker/Similar device Stroke/ CVA Phlebitis/ Varicose veins Hemophilia Is there a family history of any of the above? Yes No	Head & Neck Headaches Migraines Vision problems Ear problems Hearing loss Dizziness Sinus problems Frequent colds Other pain, where?	Infections ☐ Hepatitis ☐ Skin Conditions What? ☐ TB ☐ HIV ☐ Herpes ☐ Other, specify: ———— Do you have any other medical conditions? (e.g. digestive conditions, osteoporosis, mental illness)? Yes ☐ No ☐ What?	Respiratory Chronic cough Shortness of breath Bronchitis Asthma Emphysema Other, specify: Is there a family history of any of the above? Yes No
Women □ Pregnant Due: □ Gynaecological Conditions Specify: Are you currently receiving treatment from another health care professional? Yes □ No □ If yes, for what?	Other Conditions □ Loss of sensation Where? □ Diabetes Type? □ Allergies/Hypersensitivity What? □ Epilepsy □ Cancer Where? □ Arthritis Is there a family history of arthritis? Yes □ No □	Overall, how is your general health? Reason for massage? Do you have any: Internal pins Wires Artificial joints Special equipment	Current Medications: Condition it treats: Surgery- Date: Nature Injury- Date: Nature

Please locate areas of discomfort or pain:

Practitioner Notes:

	jaw/TMJ tooth neck/shoulder upper back elbow lower back hip leg	□ Tension □ Tenderness □ Stiffness □ Muscle cramps □ Swelling □ Restricted movement □ Bursitis □ Tendonitis □ Pain		
	Please Initial the boxes if you consent to the following:			
I understand that discussing specific areas to be treated and agreement to proceed with massage is informed consent.				
I give my consent to receive periodic e-mails and newsletters from Mountain Chiropractic and Natural Health, which may include appointment reminders, schedule changes, promotions and other helpful information which we wish to share with our clients.				
I understand that 24 hours' notice is required to cancel an appointment; otherwise a full treatment charge will apply with the exception of emergencies				
	Signature			
	Date:/			