Massage Therapy

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 ________ Gender ________ Occupation ______________

Emergency Contact Name ______________________ Emergency Contact Phone ______________

Doctor's Name ______________ Phone ______________ Last Check-Up Date ______________

Doctor's Street ______________ Unit ________ City ________ Prov. ________ Postal Code ________

Were you referred by another health care practitioner? If yes, who ______________________

Have you had a professional massage before? ☐ Yes ☐ No If yes, approximate date of last therapeutic massage ________

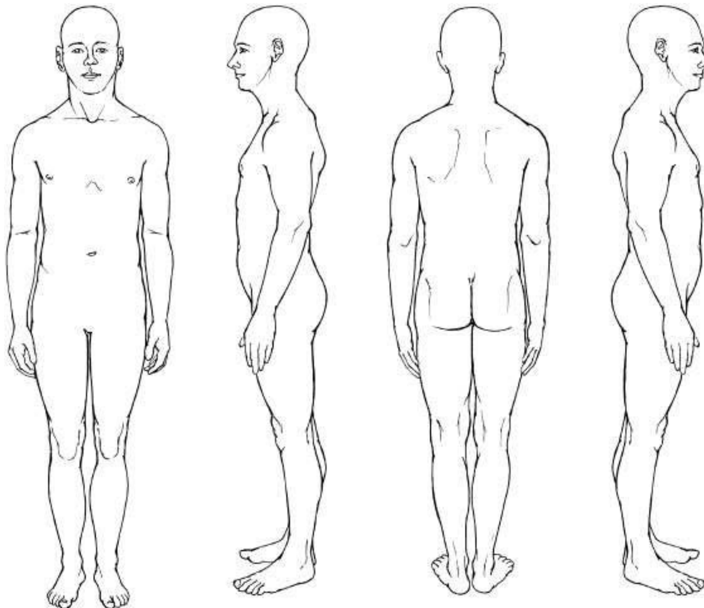
Do you see other healthcare practitioners? ☐ Chiro ☐ Physio ☐ Naturopath ☐ Osteopath ☐ Other ________

Current Medications and Conditions Treating ______________________

Previous Major Illnesses/Operations (include dates) ______________________

Major Accidents ______________________

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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____

____

Massage

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Respiratory

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

Joint/Muscle

- ☐ Jaw
- ☐ Neck
- ☐ Shoulders
- ☐ Arms
- ☐ Hands
- ☐ Upper back
- ☐ Mid back
- ☐ Low back
- ☐ Hips
- ☐ Knees
- ☐ Feet

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?

____

____

Cardiovascular

- ☐ High blood pressure
- ☐ Low blood pressure
- ☐ Heart attack/disease
- ☐ Congestive heart failure
- ☐ Stroke/aneurysm
- ☐ Pacemaker
- ☐ Varicose veins/phlebitis

Other

- ☐ Fever
- ☐ Arthritis OA/RA
- ☐ Headaches/migraines
- ☐ Loss of sensation/numbness/tingling
- ☐ Diabetes, onset ______________
- ☐ Cancer, where ______________
- ☐ Epilepsy
- ☐ Haemophilia
- ☐ Neuromuscular conditions
- ☐ Osteoporosis
- ☐ Mental illness
- ☐ Skin conditions
  what ______________
- ☐ Artificial implants / pins / plates;
  where ______________

EENT

- ☐ Vision loss/problems
- ☐ Dental problems
- ☐ Hearing loss/ear problems
- ☐ Hearing aid
- ☐ Sinus problems
- ☐ Allergies/hypersensitivity to
  type of reaction ______________

Reproductive

- ☐ Pregnant, due ______________

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 ______________

Date updated ____________ Client initial ____________ Date updated ____________ Client initial ____________

Date updated ____________ Client initial ____________ Date updated ____________ Client initial ____________