

PATIENT ENTRANCE FORM

An accurate health history is important to ensure that it is safe for you to receive a massage treatment. All information gathered for this treatment is confidential except as required or allowed by law. Written authorization will be required for release of any information. **24-hour cancellation notice is required otherwise a missed appointment fee will be charged.**

Name: _____ Date: _____

Address: _____
(Street) (City) (Province) (Postal Code)

Home Phone: _____ Cell Phone: _____

Date of Birth: _____ Age: _____ Email: _____
(Month/Day/Year)

Occupation: _____ Employer: _____

Emergency Contact: _____ Phone: _____

Medical Doctor: _____ Phone: _____

How did you hear about our clinic? Referral: _____ Website Sign Other _____

Have you ever seen a massage therapist before? Y N If yes, last visit date? _____

Are you seeking massage for relaxation or therapeutic benefits

Describe your Complaint/Problem/Injury

Mark areas of pain/discomfort

Which activities aggravate your condition?

- Work Sleep Sitting Standing Coughing
 Bending Lifting Driving Exercise Sneezing

Other: _____

Which activities relieve your condition?

- Rest Movement Cold Heat

Other: _____

Other professionals consulted for this condition?

Other health problems/previous injuries/hospitalization

When did this problem begin?

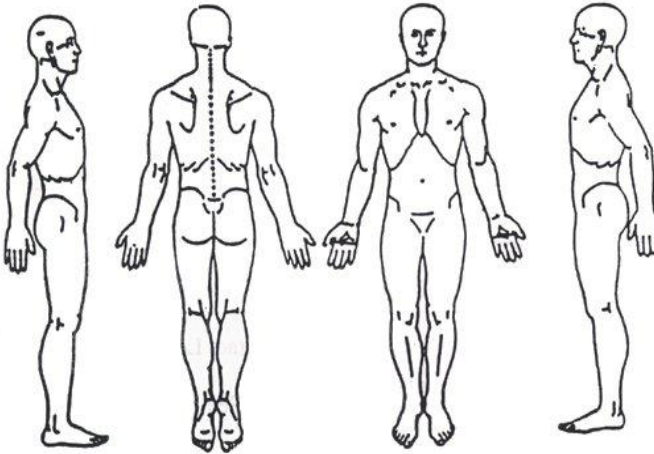
Have you had this in the past? When?

Do you have any internal pins/wires/artificial joints?

Are you currently taking any medications? Yes No If yes, what type(s)?

- Painkiller Anti-inflammatory Muscle relaxant Blood thinners Sleep

Other: _____



Please check all that apply.

HEAD / NECK

- Tension Migraines
- History of headaches
- Concussion
- Whiplash
- Tooth/Jaw/Ear pain

CARDIOVASCULAR

- High / Low pressure
- Chronic heart failure
- Poor circulation
- Heart disease
- Phlebitis
- Stroke
- Heart attack
- Pacemaker
- Arteriosclerosis
- Irregular heart beat

RESPIRATORY

- Asthma
- Chronic cough
- Shortness of breath
- Bronchitis
- Emphysema
- Pneumonia
- Sinus Problems

DIGESTIVE / URINARY

- Difficult digestion
- Constipation
- Liver / Gallbladder
- Kidney / Urinary
- Diabetes (type) _____
- Hypoglycemia
- Crohn's disease
- Irritable bowel
- Ulcers

SKIN

- Bruise easily
- Loss of sensation
- Skin condition (please explain) _____
- Varicose veins
- Athlete's foot
- Cold sores
- Plantar warts

FEMALE

- Menstrual problems
- Pregnancy
- Due Date : _____

MUSCLE / JOINTS

- Neck
- Shoulder
- Upper back
- Mid back
- Lower back
- Arms
- Chest
- Legs
- Hips
- Knees
- Fractures
- Arthritis

MENTAL ILLNESS

- Anxiety
- Depression
- Other

INFECTIOUS

- Tuberculosis
- AIDS / HIV
- Hepatitis
- Infectious skin

Present

Past

OTHER

- Hemophiliac
- Epilepsy
- Cancer (please explain)
- Fibromyalgia
- Osteoporosis
- Chronic fatigue
- Dizziness / Fainting
- Hernia
- Carpal tunnel syndrome
- Multiple Sclerosis
- Parkinson's disease

Informed Consent for Massage Therapy 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 and disclosed to the massage therapist all my medical conditions. I understand that it is my responsibility to keep the massage therapist updated on my medical history. The information provided is true and complete to the best of my knowledge. I consent to be assessed by my massage therapist, using a variety of examinations and techniques, for the conditions noted in my health history. I have read the above consent and I have had an opportunity to ask questions about my massage therapy assessment. I understand that I may withdraw my consent to assessment at any time and that the assessment will be stopped. By signing this form, I confirm my consent to assessment and intend this consent to cover the assessment discussed. I understand that all information gathered is confidential and that I must give consent for my health records to be released.

Patient Name: _____ Patient Signature: _____
 Witness: _____ Date Signed: _____

Consent for Communication

I consent to the clinic to communicate electronically with me for the purpose of scheduling appointments and appointment confirmations. Initial _____
 I consent to the clinic to communicate electronically with me for the purpose of clinic updates. ☑ Initial _____

Cancellation Policy

A cancellation fee will be charged if you cancel your appointment with less than 24 hours notice or if you do not show for your scheduled appointment. Please sign that you have read, understand and agree to this cancellation policy.

Signature: _____