Name_____ Address_____

Telephone (H)_____ (W)_____

Occupation_____ (email)_____

Date of Birth_____ Height_____ Weight_____

What brings you in for a Massage?_____

How did you hear about us □ brochure □ walk-in □ internet □ referral_____ □ other_____

Name and Address of Physician_____

Health History: □ current conditions □ past conditions

HEAD/NECK
□ contact lenses
□ earaches
□ frequent colds
□ headache/migraine
□ neck pain
□ sinus
□ TMJ
□ vision/hearing

SKIN
□ bruise easily
□ cold sores
□ herpes
□ rashes/eruptions
□ sensitive skin
□ loss of sensation
□ allergies

WOMEN
□ osteoporosis
□ heavy menstruation
□ painful menstruation
□ scant menstruation
□ menopause
□ pregnant
□ caesarian section
□ other

MUSCLES/JOINTS
□ pain
□ back pain
□ knee pain
□ leg pain
□ neck pain
□ shoulder pain
□ limitation of movement
□ stiffness/swelling

RESPIRATORY
□ asthma
□ bronchitis
□ breathing difficulties
□ chronic cough
□ emphysema
□ shortness of breath
□ smoking

DIGESTIVE/UROGENITAL
□ bladder problems
□ constipation
□ diarrhea
□ difficult digestion
□ gallbladder problems
□ kidney problems
□ liver problems
□ poor appetite
□ diabetes

CARDIOVASCULAR
□ blood pressure -High/Low
□ poor circulation
□ congestive heart failure
□ heart disease
□ phlebitis/varicosities
MD diagnosed_____
□ stroke
□ pacemaker
□ heart attack

OTHER
□ cancer
□ epilepsy
□ insomnia
□ rheumatoid arthritis
□ osteoarthritis
MD diagnosed_____
□ family history of arthritis
□ hemophilia
□ infectious conditions:
TB, HIV, Hepatitis

Healthcare:

□ Chiropractor _____

□ Physiotherapy _____

□ Naturopath _____

□ Other _____

Life Questions:

□ Regular Eating Habits
□ Regular Exercise
□ Good Sleeping Patterns
□ Previous Massage Experience

□ I feel good about life
□ I have poor energy levels
□ I suffer from too much stress
Health: □ Good □ Fair □ Poor

Special Note:

□ Surgery □ Injury □ Medication/Condition □ Pins/Wires/Artificial Joints

_____

_____

I understand that the information that I give on this form is confidential. I grant consent for my initial treatment.

I understand that there is a 24-hour cancellation notice, otherwise the full treatment fee is charged.

I will inform my therapist should anything change regarding my health status. I recognize that my health is my responsibility.

Your information will not be shared with other health care practitioners without your consent.

Files will be destroyed after 10 years from date of last treatment.

*Signature*_____ *Date*_____

Prepared for ACTIVE HEALING CENTRE