Wellness for the Body
Massage Therapy & Healing Centre

Registered Massage Therapy

2418 Lakeshore Road West, Oakville, Ontario L6L 1H7
Phone: 905.465.4595 Web: www.wellnessforthebody.com

Patient Information (please print clearly)

Name: ______________________________ Date of Birth: mm/dd/yyyy ____/____/________ Age: ______

Address: ______________________________ City: ________________ Province: ________ Postal Code: ____________

Please consider giving us a daytime phone number, in the event we need to reach you the same day as your appointment.

Phone: (H)____________________ (M)____________________ (B)____________________

Gender: ☐ Female ☐ Male Occupation: ______________________________

Email: ______________________________ Would you like to receive our monthly e-newsletter? ☐ Yes ☐ No

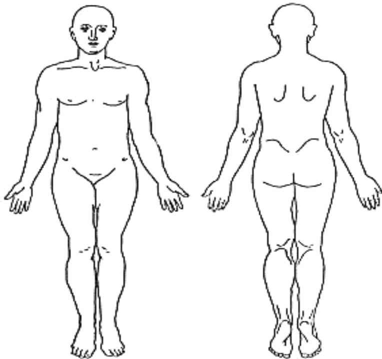
Where did you find our number? ______________________________

If online, what site referred you? ☐ Google ☐ Facebook ☐ Instagram ☐ Twitter ☐ Other: ____________________

Health History

Reason for massage: ______________________________

Indicate areas of pain or discomfort:



Notes: ______________________________

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Have you ever received a professional massage? ☐ No ☐ Yes If yes, when was your last treatment? ____________________

List other current therapies (i.e. chiropractic): ______________________________

Doctor: ____________________ Phone: ____________________ City: ____________________

Current supplements/medications (conditions they treat): ______________________________

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Surgeries/Injuries (Please list and date): ______________________________

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Please list the presence and location of any internal pins, wires, artificial joints or special equipment: ____________________

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Motor Vehicle Accident? ☐ No ☐ Yes Date: ____________________

Other accident(s): ______________________________ Date(s): ____________________

please turn over...

Please check all applicable boxes (current or past conditions)

Cardiovascular:
- ○ High blood pressure
- ○ Low blood pressure
- ○ Chest pain
- ○ Chronic congestive heart failure
- ○ Heart disease
- ○ Myocardial infarction
- ○ Phlebitis
- ○ Cardio-vascular accident
- ○ Stroke
- ○ Pacemaker or similar device
- ○ Hypertension
- ○ Angina
- ○ Mitral Prolapse
- ○ Heart Palpitations
- ○ Varicose veins
- ○ Deep vein thrombosis
- ○ Blood clots
- ○ Poor circulation
- ○ Cold hands/feet
- ○ Lymphedema
- ○ Other ________________

Skin:
- ○ Allergies (anaphylactic)
- ○ Rashes
- ○ Athletes foot
- ○ Warts
- ○ Cold sores
- ○ Eczema/psoriasis
- ○ Other (contagious) _________

Reproductive:
- ○ Pregnancy (due date: _________)
- ○ Menstruation:
  __ Absent __Painful
  __ Heavy __Light
  __ Normal __Irregular
- ○ Dysmenorrhea
- ○ Menopause:
  __Pre __Active __Post
- ○ Other ________________

Nervous System:
- ○ Herpes/shingles
- ○ Numbness/tingling
- ○ Loss of sensation
- ○ Chronic pain
- ○ Fatigue
- ○ Sleep disorder/insomnia
- ○ Chronic fatigue syndrome
- ○ Memory Loss

Other ________________

Respiratory:
- ○ Chronic cough
- ○ Bronchitis
- ○ Shortness of breath
- ○ Asthma
- ○ Emphysema
- ○ Smoking
- ○ Pneumonia
- ○ Other ________________

Musculo-skeletal:
- ○ Fibromyalgia
- ○ Bone or joint disease
- ○ Tendonitis
- ○ Bursitis
- ○ Fractures
- ○ Osteoarthritis
- ○ Rheumatoid arthritis
- ○ Sprains/strains
- ○ Swelling
- ○ Stiffness
- ○ Spasms/cramps
- ○ Pain (check area)
  __Jaw/TMJ __Neck
  __Shoulder __Elbow
  __Wrist __Hip __Knee
  __Ankle __Low back
  __Upper back __Mid Back

Digestive:
- ○ Poor digestion
- ○ Constipation
- ○ Gas/bloating
- ○ Nausea/vomiting
- ○ Diarrhea
- ○ Ulcer
- ○ Irritable bowel syndrome
- ○ Liver/gall bladder
- ○ Kidney/bladder issues
- ○ Kidney/gall stones
- ○ Other ________________

Infectious Diseases:
- ○ Hepatitis
- ○ Tuberculosis
- ○ HIV
- ○ Venereal Disease
- ○ Herpes
- ○ Dermatitis
- ○ Other ________________

Other:
- ○ Diabetes
- ○ Anemia
- ○ Dizziness
- ○ Vertigo
- ○ Earaches
- ○ Ringing in ears
- ○ Sinus problems
- ○ Loss of smell/taste
- ○ Vision/hearing loss
- ○ Thyroid issues
- ○ Hormone imbalance
- ○ Cancer
- ○ Epilepsy
- ○ Anxiety/depression
- ○ Panic Attacks
- ○ Headaches/migraines
  How often: __________
- ○ Allergies:
  __Food __Drug
  __Environmental
- ○ Other ______________

Client Consent Statement

In keeping with the Health Care Consent Act (1996), it is my choice to receive massage therapy. I understand that an assessment by a therapist is required to determine the best course of treatment. I am aware that all information provided is private and confidential and will not be released without my written consent. I agree to communicate with my massage therapist at any time if I have any questions, if I feel uncomfortable, or I feel that my wellbeing is being compromised. I will consent to the massage therapist working only on those areas of my body that I am comfortable with. I am aware that I may remove only the clothing with which I am comfortable and may terminate the treatment at any time at my discretion. I am also aware of the possible side effects from a massage treatment such as temporary muscular discomfort (24-48hrs post treatment), bruising and possible dizziness. I understand the therapist will recommend remedial exercises and home care. I am aware the session length includes change time.

Cancellation & Fee Policy

For a full detailed price list: www.wellnessforthebody.com

We require 24 hours' notice if you are unable to make your scheduled appointment. After an initial warning, there is a charge of $45.00 for a second missed appointment. All subsequent missed appointments will then be billed at the full regular fee.

Payment is due at the time services are rendered. This policy applies to all our patients. Patients with extended health care coverage should note, our office does not file claims on your behalf, nor bill your insurance company directly.

I understand and am aware of the Cancellation & Fee Policy. I also agree that if I am late for my appointment, I will receive the remainder of the appointment time and will be responsible for the full payment of the scheduled appointment.

Signature: ____ Date: ____________________________________

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