

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

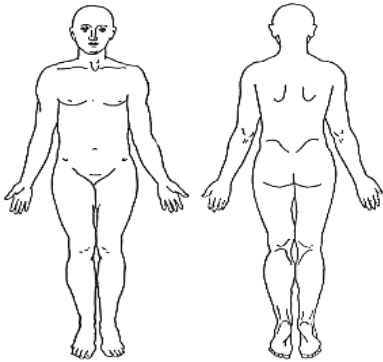
Where did you find our number? _____

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

Health History

Reason for massage: _____

Indicate areas of pain or discomfort:



Notes: _____

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): _____

Surgeries/Injuries (Please list and date): _____

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

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.

Cancellation & Fee Policy

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.

I am aware the session length includes change time.

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

Signature: _____ Date: _____
