Strength and Balance Therapeutic Massage Inc.

CLIENT HEALTH HISTORY

*All information provided is confidential. Massage Therapists are not medical doctors and, therefore, will not diagnose illness, diseases or disorders. Medical concerns should be directed to your physician.

NAME:_____**DATE**:_____

ADDRESS:_____ **PHONE** res: _____bus:_____
cell:_____

CITY:_____ **POSTAL CODE**:_____

E-MAIL:_____

OCCUPATION:_____ **D.O.B.**:_____

ACTIVITIES/HOBBIES:_____

EMERGENCY CONTACT: Name:_____ Relationship:_____
Phone: res:_____ other ph.#:_____

How did you hear about us?_____

Medication, including prescriptions, over the counter meds, vitamins & herbal remedies:
_____

Past surgeries (include dates):
_____
_____
_____

Accidents/Injuries (* Please be very specific with information regarding motor vehicle accidents- include date, details, injuries, treatments, litigation etc): _____
_____
_____
_____
_____
_____

Are you currently under the care of any other health care providers? (eg. Chiropractor, Physiotherapist, MD, Naturopath, Dietician, etc…) If so, when was your last visit?

- _____Name:_____Last visit:_____
- _____Name:_____Last visit:_____
- _____Name:_____Last visit:_____

Please check (√) *areas of concern* and *past or present conditions*. Include a brief explanation as well as approximate date of diagnosis.

AREAS OF CONCERN

- ☐ Jaw _____
- ☐ Back _____
- ☐ Neck_____
- ☐ Chest_____
- ☐ Shoulders_____
- ☐ Stomach/Abdomen_____
- ☐ Arms_____
- ☐ Hips _____
- ☐ Wrists_____
- ☐ Legs _____
- ☐ Hands_____
- ☐ Knees/Ankle/Feet_____

Other:_____

_____

CONDITIONS

- ☐ Allergies_____
- ☐ Hepatitis _____
- ☐ Anxiety_____
- ☐ H.I.V. _____
- ☐ Arthritis (osteo or rheum)_____
- ☐ Kidney disorder_____
- ☐ Asthma_____
- ☐ Liver disease _____
- ☐ Bleeding disorder_____
- ☐ Mental illness _____
- ☐ Depression _____
- ☐ Pregnant or trying to get pregnant_____
- ☐ Diabetes (insulin dependent?)_____
- ☐ Smoker _____
- ☐ Cancer_____
- ☐ Skin (rashes,eczema…)_____
- ☐ Carpal Tunnel _____
- ☐ Stress _____
- ☐ Cold/Flu (currently suffering)_____
- ☐ Tendonitis _____
- ☐ Constipation/Diarrhea _____
- ☐ Varicose veins _____
- ☐ Epilepsy_____
- ☐ Warts _____
- ☐ Fibromyalgia _____
- ☐ Open wounds _____
- ☐ Headaches/Migraines_____
- ☐ Osteoporosis _____
- ☐ Heart conditions_____
- ☐ Other: _____
- ☐ Hemophilia _____ _____
- ☐ High/low blood pressure _____ _____

CONSENT FORM

- I release my therapist(s) and Strength and Balance Therapeutic Massage Inc. from any and all liability for injuries or problems that result from missing or incorrect information provided on this history form and in subsequent sessions.
- I give permission for my case file to be discussed with other Massage Therapists at Strength and Balance Therapeutic Massage Inc.
- A client has the right to refuse, modify or terminate treatment at any time.
- A therapist has the right to refuse, modify or terminate treatment at any time if there is reasonable cause.
- I acknowledge that I have read and understand this consent, and agree to its conditions.

SIGNED:_____DATE:_____

WE REQUIRE 24HOURS NOTICE OF CANCELLATION OR THE PRICE OF THE APPOINTMENT WILL BE CHARGED.