MASSOTHÉRAPIE
Massage Addict

Health History and Entrance Form

A complete health history helps us ensure it is safe to provide you with a massage treatment; please let us know if your status changes so we can update your form. All information given to us is confidential.

Name _____ Email _____
We collect your email address to send you appointment reminders. Your email address will never be shared with a third party.

Home Phone _____ Cell Phone _____ Work Phone _____

Street _____ Unit _____ City _____ Prov. _____ Postal Code _____

Date of Birth (MM-DD-YY) _____ Age _____ Occupation _____

How did you hear about us? _____

Do you have insurance coverage for massage? ☐ Yes ☐ No If yes, were you referred by your doctor? ☐ Yes ☐ No

Doctor's Name _____ Phone _____ Last Check-Up Date _____

Doctor's Street _____ Unit _____ City _____ Prov. _____ Postal Code _____

Have you had a professional massage before? ☐ Yes ☐ No If yes, approximate date of last therapeutic massage _____

Do you see other healthcare practitioners? ☐ Chiro ☐ Physio ☐ Naturopath ☐ Osteopath ☐ Other _____

Current Medications _____

Previous Major Illnesses/Operations (include dates) _____

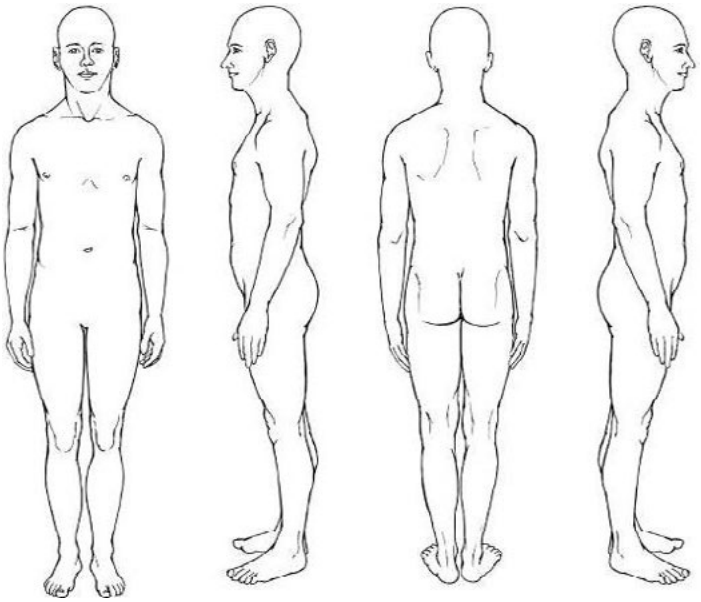
Allergies/Hypersensitivities _____

Family History of _____

Major Accidents (include dates) _____

Other Serious Medical Conditions _____

Please indicate areas you would like us to focus on and your primary area of complaint.



What is your primary complaint?

_____

_____

_____

_____

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General Symptoms

☐ Fainting / Dizziness
☐ Difficulty Sleeping / Fatigue
☐ Stress
☐ Headaches / Migraines
☐ Nervousness
☐ Numbness / Tingling; Where: _____
☐ Paralysis

Skin

☐ Rashes
☐ Excessive Dryness
☐ Acne
☐ Psoriasis
☐ Eczema
☐ Skin Cancer
☐ Bruise Easily

Infections

☐ Hepatitis
☐ Tuberculosis
☐ HIV / AIDS
☐ Herpes
☐ Athlete's Foot
☐ Warts

Respiratory

☐ Chronic Cough
☐ Bronchitis
☐ Asthma
☐ Shortness of Breath
☐ Emphysema
☐ Family History of _____

Lifestyle (check all that apply)

Regular Exercise	☐Yes	☐No	☐Mostly
Drink Plenty of Water	☐Yes	☐No	☐Mostly
8 Hours of Sleep nightly	☐Yes	☐No	☐Mostly
Good Eating Habits	☐Yes	☐No	☐Mostly

What is your general health?

_____

Joint / Muscle Discomfort

☐ Jaw
☐ Neck
☐ Shoulders
☐ Arms
☐ Hands
☐ Upper Back
☐ Mid Back
☐ Low Back
☐ Hips
☐ Legs
☐ Knees
☐ Feet
☐ Bursitis
☐ Arthritis
☐ Family History of Arthritis

Do You Have / Had?

☐ Diabetes Onset _____
☐ Cancer; Where _____
☐ Epilepsy
☐ Aneurysm / Stroke
☐ Neuromuscular Conditions
☐ Hypo / Hyper Glycaemic
☐ Depression
☐ Multiple Sclerosis
☐ Thyroid Problems
☐ Fibromyalgia
☐ Osteoporosis
☐ Mental Illness
☐ Artificial Implants / Pins / Plates;
Where _____

Male / Female

☐ Prostate
☐ Pregnant; Due Date _____
☐ Menstrual Cramping
☐ Menstrual Irregularity
☐ Birth Control
☐ Vaginal Pain / Infections
☐ Breast Pain / Lumps
☐ Menopausal

Cardiovascular

☐ High Blood Pressure
☐ Low Blood Pressure
☐ Heart Attack / Disease
☐ Congestive Heart Failure
☐ Stroke / Aneurysm
☐ Heart Murmur
☐ Pacemaker
☐ High Cholesterol
☐ Swelling of Ankles
☐ Cold Hands / Feet
☐ Poor Circulation
☐ Feet
☐ Varicose Veins / Phlebitis
☐ Family History of _____

Gastrointestinal

☐ Poor / Excessive Appetite
☐ Excessive Thirst
☐ Gas / Bloating
☐ Colitis
☐ Crohn's
☐ Constipation
☐ Diarrhea
☐ Nausea / Vomiting
☐ Ulcer
☐ Abdominal Cramps
☐ Gall Bladder Problems
☐ Liver Problems

EENT

☐ Vision Problems
☐ Dental Problems
☐ Sore Throat
☐ Ear Aches
☐ Hearing Difficulty
☐ Hearing Aid
☐ Stuffed Nose / Sinus
☐ Allergies / Hypersensitivity to _____
Type of Reaction _____
☐ Swollen Glands

Please read and sign:

- I attest that the information I have provided is true and complete to the best of my knowledge.
- I understand the information I have provided on this form is confidential and will not be released without my written consent.
- I understand that the therapist can end treatment at anytime due to inappropriate behaviour.
- I consent to a health assessment/reassessments and therapeutic massage treatment at Massothérapie Massage Addict.
- I authorize Massothérapie Massage Addict to contact my doctor or other health care professional listed above if required for treatment purposes.
- I understand that all sessions include a pre-health assessment and change time.
- I understand 24 hours notice is required to reschedule all future appointments, or full charges will apply.
- I authorize my health file to be transferred to another Massothérapie Massage Addict clinic if I relocate or a new Massothérapie Massage Addict clinic opens closer to my household.

Signature _____ Today's Date sdsds