CENTER FOR HEALTHY LIVING

HEALTH HISTORY FORM

Last Name:______________________ First Name:______________________

Address:______________________ City/Province/Postal:______________________

Email:______________________ Sex: M / F

Home: (____)______________ Work: (____)______________ Cell: (____) ______________

Occupation: ______________________ ______________________( )______

Emergency Contact + Number

DOB:(mm/dd/yyyy)______________________

Name of Family/Critical care doctor: ______________________

Name of Insurance Provider: ______________________

Who may we thank for referring you to our clinic? ______________________

Medical History

- □ Angina
- □ Cancer
- □ Cardiac Pacemaker
- □ Any other heart problems (past or present)
- □ Ostearthrisis
- □ Osteoporosis
- □ Pregnant
- □ Radiotherapy/Chemotherapy (in past 6 months)
- □ Steroids
- □ Surgery
- □ Blood thining medications
- □ Weight Loss (sudden, >10lb)
- □ Change in bowel/bladder function

Other Symptoms

- □ Abdominal Pain
- □ Accident
- □ Allergies
- □ Anxiety
- □ Arthritis
- □ Broken Bones
- □ Circulatory/Vascular Disease
- □ Decreased range of motion
- □ Diabetes
- □ Disk Problem
- □ Headaches
- □ High blood pressure
- □ Joint Ache
- □ TMJ Problems
- □ Low Back Pain
- □ Mid Back Pain
- □ Upper Back Pain
- □ Medications Y / N
- □ Menstrual
- □ Neck Pain
- □ Nervous Tension
- □ Numbness/Tingling
- □ Sciatica
- □ Sleep disturbances
- □ Sprains
- □ Skin Conditions: ______________________
- □ Varicose Veins
- □ Whiplash

List of Medication: ______________________

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In regards to your current condition:

Are you experiencing any pain at the moment? Y / N

If you answered "Yes", What is your main complaint & symptoms: ______________________

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Pain Scale: How servere are your symptoms out of 10?

Physical Activities

□ Running □ Walking □ Sports □ Biking □ Gym □ Swimming □ Yoga □ Other

Other : ______________________

MASSAGE THERAPY CONSENT FORM

I understand that the information I provided is accurate and I will notify the therapist as to any changes in my health history. I also understand that massage therapists are not qualified to perform skeletal adjustments, diagnose or prescribe and in turn will not look to the therapist for such treatment. I am also aware of the benefits, potential adverse effects, treatment procedures and treatment goals, therefore, waiving Center for Healthy Living and its therapists of all responsibility for my massage treatment within the clinic.

I understand the following cancellation policy: Less than 24 hours or No Shows will be charged for the appointment.

It is also understood that any illicit or sexually suggestive remarks or advances made by me will result in immediate termination of the session and I will be liable for payment for the appointment.

Client Signature: ___________________

Date: _________________