CENTER FOR HEALTHY LIVING

MASSAGE
HEALTH HISTORY FORM

Last Name:_____ First Name:_____

Address:_____ City/Province/Postal:_____

Email:_____ Sex: M / F / Other

Home: (____)_____ Work: (____)_____ Cell: (____) _____

Occupation: _____ _____(___)_____

Emergency Contact Name + 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)
□ Osteoarthritis
□ Osteoporosis
□ Pregnant
□ Radiotherapy/Chemotherapy (in past 6 months)
□ Steroids
□ Surgery
□ Blood thinning 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

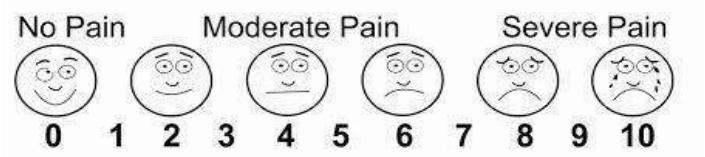
List of Medication: _____

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: _____

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



PHYSICAL ACTIVITES

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

Other : _____

CENTER FOR HEALTHY LIVING

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 it's therapists of all responsibility for my massage treatment within the clinic.

By providing your email, you consent to receiving appointment reminders, receipts and other communication from Center for Healthy Living.

CANCELLATION & NO SHOW POLICY

I understand that cancellations or rescheduling must be made a minimum of 24 hours prior to appointment. I agree to pay in full, charges for missed appointments or cancellations made less than 24 hours notice.

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.

I have read the above consent, and I have the opportunity to ask questions about its content.

_____ _____

Client Name (please print) Client Signature

_____

Date Signed