

# MASSAGE THERAPY

Name: \_\_\_\_\_ Date: \_\_\_\_\_  
Address: \_\_\_\_\_  
City: \_\_\_\_\_ Province: \_\_\_\_\_ Postal Code: \_\_\_\_\_  
Home #: \_\_\_\_\_ Cell #: \_\_\_\_\_ Bus #: \_\_\_\_\_  
Email: \_\_\_\_\_  
Occupation: \_\_\_\_\_ Employer: \_\_\_\_\_  
Emergency Contact: \_\_\_\_\_ Emergency Contact #: \_\_\_\_\_  
Date of Birth: \_\_\_\_\_ Age: \_\_\_\_\_ Doctor: \_\_\_\_\_  
Chiropractor: \_\_\_\_\_ Physio: \_\_\_\_\_  
Who may I thank for referring you? \_\_\_\_\_

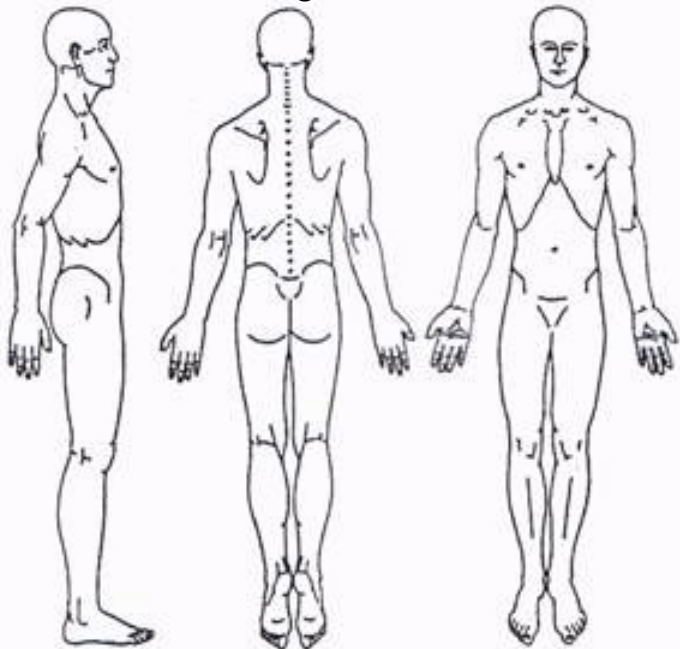
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Are you undergoing any therapies? YES NO List: \_\_\_\_\_  
What else are you doing for your health? (ie exercise) \_\_\_\_\_  
When did you last visit your doctor? \_\_\_\_\_ Reason: \_\_\_\_\_  
List past surgeries and dates: \_\_\_\_\_  
List past injuries and dates: \_\_\_\_\_  
Are you taking any medications? YES NO (please include any vitamins or dietary supplements)  
Please list and reason for taking: \_\_\_\_\_

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Do you sleep well? YES NO  
Do you suffer from anxiety or worry? YES NO  
Are you pregnant YES NO If yes, which trimester 1 2 3  
Do you wear prostheses (ie: glasses, contacts, glass eye, artificial joint/limb, metal plates, pins or wires, dentures, hearing aid) YES NO If yes, please list: \_\_\_\_\_  
Is this your first massage? YES NO  
What are your expectations of massage? \_\_\_\_\_

**Please mark the areas of pain or discomfort on the figures shown:**



**Are you presently experiencing any of the following? (please circle)**

Inflammation  
Headache  
Cuts, bruises, burns  
Decrease range of motion  
Cold/flu  
Rash



**Do you have problems with any of the following? (please check all that apply)**

**ENDOCRINE SYSTEM:**

- Diabetes/hypoglycemia
- Hypo/hyperthyroidism

**CARDIOVASCULAR**

- High/Low blood pressure
- Heart Disease
- Phlebitis
- Varicose veins
- Circulation problems
- Anemia
- Thrombosis
- Arteriosclerosis
- Blood clot
- Aneurysm
- Cardiac insufficiency

**IMMUNE & LYMPHATIC**

- Rheumatoid Arthritis
- Chronic Fatigue Syndrome
- Environmental Illness
- HIV/AIDS
- Allergies

**RESPIRATORY**

- Asthma
- Emphysema
- Sinus condition
- Tuberculosis

- Bacterial Pneumonia

**MUSCULOSKELETAL**

- Osteoporosis
- Fibromyalgia
- Bursitis
- Gout
- Back Pain
- Scoliosis
- Foot, arm or hand problems
- Osteomyelitis
- Osteoarthritis

**NERVOUS SYSTEM**

- Vision problems
- Hearing loss/problems
- Loss of sensation
- Nerve damage/pain
- Headaches
- Mental/emotional problems
- Multiple Sclerosis

**REPRODUCTIVE/URINARY**

- PMS
- Painful menstruation
- Endometriosis
- Prostate problems
- Urinary problems
- Kidney disease

**DIGESTIVE**

- Prolonged constipation
- Diarrhea
- Crohn's Disease
- Colitis
- Diverticulitis
- Ulcer

**INTEGUMENTARY (SKIN)**

- Psoriasis
- Eczema
- Warts
- Herpes
- Shingles
- Syphilis
- Scabies
- Hepatitis B (blood open wounds)
- Allergy to oils
- Pitted Edema

**PLEASE NOTE THAT PAYMENT IS DUE AT THE TIME OF TREATMENT. FAILURE TO CANCEL AN APPOINTMENT 24 HOURS IN ADVANCE WILL RESULT IN A CANCELLATION FEE. A CHARGE WILL ALSO APPLY TO MISSED APPOINTMENTS. THE COST WILL BE THE FULL AMOUNT OF THE MISSED APPOINTMENT**

**PATIENT CONSENT**

I, \_\_\_\_\_ understand that massage is given for the purpose of stress reduction, relief from muscle tension, spasm, scar tissue remodeling, pain relief, or increasing blood circulation to restricted tissue.

I understand that the massage therapist does not diagnose illness, disease, or any other mental or physical disorder. As such the massage therapist does not prescribe medical or pharmaceutical treatment, nor do they perform spinal manipulations. I am aware massage is not a substitute for medical examination or diagnosis and that it is recommended that I see a physician for any physical ailment I might have.

I have stated all my known medical conditions and take it upon myself to keep the massage therapist informed of any changes in my physical health.

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Guardian if under 18 years