POISED
MASSAGE THERAPY

Confidential Case History

Name: _____ Date: _____

Address: _____City:_____ Postal code: _____

Home Phone: _____ Date of birth: dd ___ mm____ yr _____ email: _____

Bus Phone: _____ Occupation: _____ Referred by: _____

MD name: _____ MD address: _____

Are you seeking massage for relaxation? ☐ Yes ☐ No Do you have a specific complaint? Please explain:

_____

How would you describe your general health status? _____

Have you ever seen a massage therapist before? ☐ Yes ☐ No If yes, when was last visit? _____

Are you interested in strategies to help you continue to feel well or even better? ☐ Yes ☐ No

Do you now or have you ever had any of the following:

Respiratory

☐ Chronic Cough
☐ Shortness of breath
☐ Bronchitis
☐ Asthma
☐ Emphysema
☐ Smoker

Infections

☐ Hepatitis
☐ Infectious Skin Condition
☐ TB
☐ HIV

Women

☐ Pregnant (Due:_____)
☐ Gynecological conditions, describe _____
☐ Menstrual Problems

Cardiovascular

☐ High blood pressure
☐ Low blood pressure
☐ Chronic congestive heart failure
☐ Heart Attack
☐ Phlebitis
☐ Stroke/CVA
☐ Pacemaker or similar device
☐ Heart Disease
☐ Poor Circulation
☐ Varicose Veins

Head/Neck

☐ Vision problems
☐ Vision loss
☐ Ear problems
☐ Hearing loss
☐ Dizziness
☐ Headaches
☐ Migraines
☐ Jaw pain/dental problems
☐ Whiplash

Skin

☐ Eczema
☐ Psoriasis
☐ Skin irritations
☐ Plantar Warts
☐ Athletes Foot
☐ Skin Condition (Please specify:_____)

Digestive/Urinary

☐ Irritable Bowel
☐ Constipation
☐ Liver/ Gallbladder
☐ Kidney/ Urinary
☐ Crohn's Disease
☐ Ulcers
☐ Diabetes (Type/onset: _____)
☐ Hypoglycemia

Other Conditions

☐ Fibromyalgia
☐ Allergies (Type/Anaphylaxis:_____)
☐ Epilepsy
☐ Cancer (Type:_____)
☐ Arthritis (Family history of arthritis ☐ Yes ☐ No)
☐ Osteoporosis
☐ Fainting/ dizziness/ loss of consciousness
☐ Hernia

Current medication(s) and condition(s) it treats: _____

Surgery, dates: _____

Injury, dates: _____

Present involvement in other Health Care: □ Yes □ No If yes, please specify: _____

Other medical conditions(eg. Depression, digestive, hemophilia, mental illness, osteoporosis, etc)_____

_____

Of special note: (presence of internal pins, wires, artificial joints, special equipment): _____

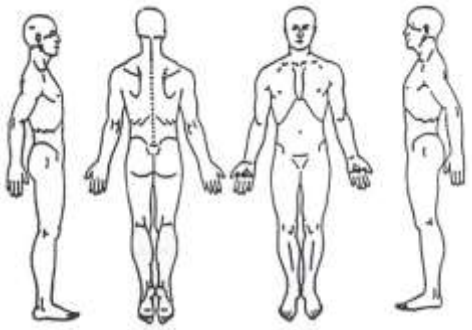
Are you currently experiencing any of the following?.....

Pain: □ Yes □ No What type? (dull, sharp,shooting…)
Where? Circle areas on body diagram

Stiffness: □ Yes □ No What type? (muscle, skin, joint…)
Where? Indicate with an X on body diagram

Numbness: □ Yes □ No What type? (tingling, lack of sensation…)
Where? Indicate with ////// on diagram

Previous occurrence of above symptoms? □ Yes □ No



An accurate health history is important to ensure that it is safe for you to receive a massage treatment. If your health status changes in the future, please let us know.

The registered massage therapists of Poised Massage Therapy make every effort to ensure that your treatment is safe and effective. Massage therapy involves manipulation of soft tissues and joints of the body, and the approach to treatment may vary depending upon the patients' condition(s). At any time before or during the massage therapy treatment, you have the right to ask that the treatment or portion of the treatment be discontinued or inquire about the purpose of any technique being used. If at any time you have any questions or concerns related to the treatment, the therapists of this clinic encourage you to communicate with them so that there may be clarification or modification of the treatment

This case history form will be kept as part of your patient file. All information within your file, including your case history form will be kept confidential and will not be released without your prior consent. Our privacy statement is available upon request. If you have any questions or concerns, please contact our privacy information officer.

Fee Schedule

60 Minute Massage	$ 90 HST Included
90 Minute Massage	$ 130 HST Included
120 Minute Massage	$ 170 HST Included

Payment is due at the time of service and we will provide you with a receipt you can submit to your insurance company for possible reimbursement.

Cancellation Policy

To avoid charges, please provide a minimum of 12 hours notice for cancellation. A 100% cancellation fee will be charged if you cancel your appointment with less than 12 hours notice or if you do not show for your scheduled appointment.

I consent to the clinic to communicate with me for the purpose of scheduling appointments, appointment confirmations, clinic updates and newsletters. □ Yes □ No

_____ _____

Client Signature (or Parent/Guardian) Date