

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

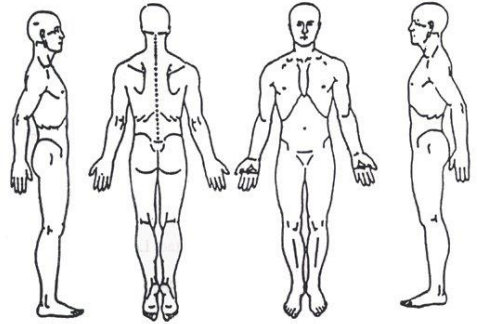
Stiffness: Yes No What type? (muscle, skin, joint...)

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. All information gathered for this treatment is confidential.

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.

If you have any questions or concerns, please contact our privacy information officer.

Fee Schedule

60 Minute Massage	\$ 100.01 HST Included
90 Minute Massage	\$ 140 HST Included
120 Minute Massage	\$ 190 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. The following cancellation fees will apply if you cancel your appointment with less than 12 hours notice or if you do not show for your scheduled appointment.

60 minute treatment cancellation	\$55.00
90 minute treatment cancellation	\$90.00
120 minute treatment cancellation	\$100.00

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