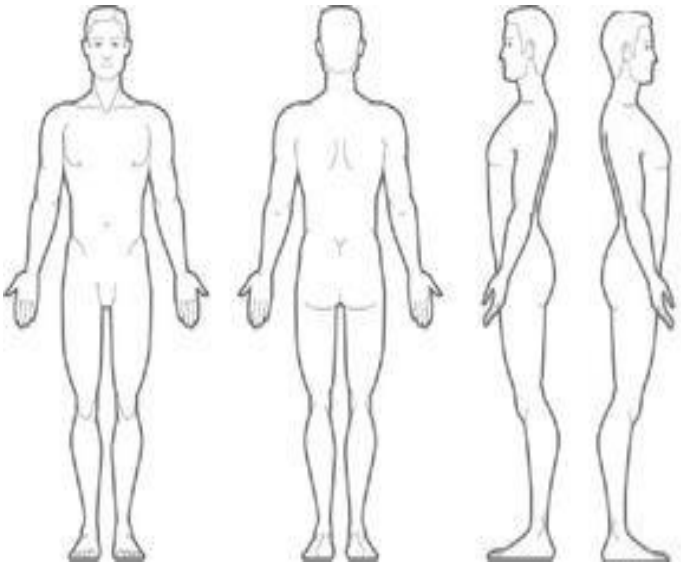
Health History

A complete health history will help me provide you with a safe and effective massage. All information on this form is confidential and will not be shared to anyone without your consent.

Name:_____ Email:_____
Phone number:_____ Street Address _____ unit_____
City_____ Prov._____ Postal code_____Date of Birth(M/D/Y)_____ Age_____
Occupation _____ How did you hear about me? _____
Do you have insurance coverage for Massage? □Yes □No Provider?_____
Policy # _____ ID # _____ Insured Members name _____
Doctors name_____ Doctor phone_____
Have you had a professional massage before? □Yes □No Date of last treatment_____
Do you see other healthcare? □Physiotherapy □Chiropractic □Osteopath □Naturopath □Other_____
Current Medications_____
Major illness/operations_____
Allergies/hypersensitivites_____
Major accidents_____
Other serious medical conditions_____
Areas you DO NOT want treated_____

Please indicate areas you would like focused on.



What is your primary complaint?

_____
_____
_____
_____
_____
_____

Please read and sign:

- The information provided is complete and accurate to the best of my knowledge.
- I understand the information on this from is confidential and will not be released without my consent.
- I understand the therapist or myself can end treatment at any time due to inappropriate behaviour.
- I consent to health assessments/reassessments and therapeutic massage treatment.
- I understand 24 hrs notice is required to cancel appointments or charges may apply.

Signature:_____ Date:_____