Health & Fitness Your Way

WELLNESS CENTRE

MASSAGE THERAPY NEW CLIENT FORM

CHART #: _____ CASE HISTORY DATE: _____

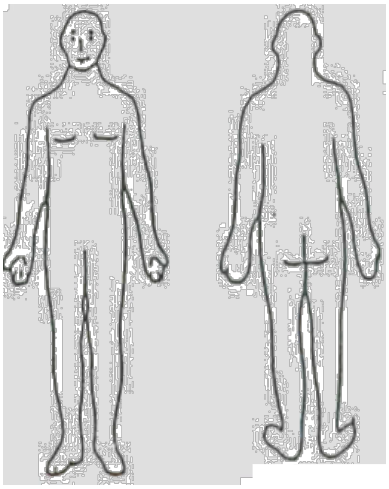
Name: _____
Last First Preferred
Address with Postal Code: _____
Phone Number: Home (____) _____ Work (____) _____ Cell (____) _____

Email: _____ Age: _____ Sex: M F
Emergency Contact :_____ Contact Info:_____
Height: _____ Weight: _____
Are you receiving chiropractic care or other medical treatment?_____
_____
Have you had **MASSAGE THERAPY** before? _____
Accident, Injuries or surgeries more than five years ago?_____
_____
Less than 5 years ago? _____

YOUR MEDICAL DOCTOR:
Doctor'sName:_____
When did you last consult a doctor and for what reason? _____
Are you currently taking any medication? _____ What? _____

PRESENT CONDITION AND HISTORY:

On the drawings
To the right,
Please shade in the areas of
Discomfort:



Describe the chief complaint which presently exists: _____
_____
_____
When did you notice this condition? _____
Did something in particular happen to cause these symptoms?_____
_____
Does anything in particular make it better or worse? _____
_____
What have you done to care for this condition? _____
_____
What type of relief, if any, did this provide? _____
_____

Are you currently experiencing any of the following conditions?

__ Pregnancy __ Flu or Cold __ Infection __ Inflammation
__ Fever __ Contagious Disease

Have you ever experienced any of the following conditions?

___AIDS
___High Blood Pressure
___Bursitis
___Low Blood Pressure
___Swollen feet of legs
___Heart trouble
___Varicose Veins
___Allergies
___Tumors
___Cancer
___Broken Bones
___Anemia
___Sciatica
___Disc Problems
___Hemophilia
___Poor Circulation
___Excess Stress
___Numbness / tingling
___Insomnia
___Headaches
___Migraines
___Diabetes
___Seizures
___Skin Problems
___Digestive Problems
___Constipation
___Anxiety
___Epilepsy/ Seizures
___Muscle spasms
___Arthritis
___Stroke
___Phlebitis
___Sprains
___Strains
___Back Pain
___Neck Pain
___Joint Problems
___Muscle Tension

For Women Only:
___Excessive Bleeding
___PMS
___Menstrual cramps
___Lack of periods
___No. of Pregnancies
___No. of Births

HABITS

Substance use: Alcohol__Y__N Tobacco__Y__N Caffine__Y__N
Sugar___Y___N Recreational Drugs___Y___N

Sleep difficulties? Describe: _____
_____
Do you wear contact lenses? _____

PHYSICAL ACTIVITY: _____Heavy _____Medium _____Light

How often do you exercise?_____ What type?_____
_____
Where do you hold stress in your body?_____
Do you have any especially tender-to-touch areas?_____
_____
Why have you come for a massage?_____

I understand that massage is given here for the purpose of stress reduction; relief from muscular tension and for facial adhesions, spasm, or pain; or for increasing circulation or energy flow.

I understand that the massage therapist does not diagnose illness, disease, or any other physical or mental disorder. As such, the massage therapist does not prescribe medical or pharmaceutical treatment, nor do they perform spinal manipulations. It has been made clear to me 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 updated on my physical health.

I understand that payment is expected at the time of the visit unless previous arrangements have been made, and that if I fail to cancel an appointment 24 hours in advance, I will be charged for the missed appointment.

_____ _____
(Signature) (Date)