Massage

APPLEBY TOTAL HEALTH

Chiropractic | Massage | Physiotherapy | Nutrition | Acupuncture | Naturopathy

HEALTH HISTORY FORM

An accurate health history is important to ensure that it is safe for you to receive a massage treatment. All information gathered for this treatment is confidential except as required or allowed by law. Written authorization will be required for release of any information.

24 hour cancellation notice is required otherwise a missed appointment fee will be charged. This form must be updated annually.

General Information

First Name:_____ **Last Name:**_____
(this is how your name will appear on your receipt)

Address:_____ **Tel. Home:**_____

City:_____ **Province:**_____ **Tel.Business:**_____

Postal Code:_____ **Date of Birth: / /** **Tel. Cell:**_____

Gender: M/F **Occupation:**_____ **Email:**_____

Primary Health Care Physician:_____ **Physician Tel. No.:**_____

Address of Physician:_____

Emergency Contact Person:_____ **Emergency Contact Person Tel. No.:**_____

1st Massage Therapy Treatment: Yes/No **General Health Status: Poor Average Good Excellent**

Primary Complaint:_____

Were you referred to this office? If yes, please provide their name:_____

How did you first hear about Appleby Total Health:_____

Personal Information and Privacy Policy:

All personal information remains the protected and confidential and will not be released without your previous written consent. I may view the Appleby Total Health privacy policy in full at any time.

HEALTH HISTORY: (please check all that apply)

Musculoskeletal

- □ Bone or joint disease
- □ Tendonitis
- □ Bursitis
- □ Fractures:_____
- □ Rheumatoid Arthritis
- □ Osteoarthritis
- □ Sprains/Strains
- □ Headaches
- □ Migraines
- □ Jaw pain/TMJ Syndrome
- □ Spasms/Cramps
- □ Other:_____

Soft Tissue/Joint Dysfunction:

- □ Ankles (Left___/Right___)
- □ Arms (Left___/Right___)
- □ Feet (Left___/Right___)
- □ Hands (Left___/Right___)
- □ Hips (Left___/Right___)
- □ Knees (Left___/Right___)
- □ Legs (Left___/Right___)
- □ Low Back (Left side____/Right side____)
- □ Mid Back (Left side____/Right side____)
- □ Neck (Left side____/Right side____)
- □ Shoulders (Left__/Right__)
- □ Upper Back (Left side____/Right side____)

Skin:

- □ Allergies:_____
- □ Skin Irritations
- □ Athlete's Foot
- □ Warts
- □ Melanoma
- □ Other:_____

Cardiovascular/Circulatory

- □ Heart disease
- □ Varicose Veins
- □ Blood clots
- □ High Blood Pressure
- □ Low Blood Pressure
- □ Chronic congestive heart failure
- □ Myocardial Infarction
- □ Stroke
- □ Phlebitis
- □ Pacemaker
- □ Thrombosis/Embolism
- □ Cold hands___/Feet___

Is there a family history of any of the above: Yes/ No

Digestive:

- □ Constipation
- □ Gas/Bloating
- □ Diverticulitis
- □ Irritable Bowel Syndrome
- □ Crohn's/Colitis
- □ Other:_____
- □

Infectious Diseases:

- □ Hepatitis (Type:_____)
- □ TB
- □ HIV
- □ Respiratory Conditions
- □ Skin Conditions
- □ Other:_____

Respiratory:

- □ Chronic Cough
- □ Shortness Of Breath
- □ Emphysema
- □ Bronchitis
- □ Asthma
- □ Other:_____

Is there a history of any of the above: Yes/No

Neurological:

- □ Burning
- □ Numbness
- □ Tingling
- □ Stabbing
- □ Loss of Sensation
- □ Cerebral Palsy
- □ Herniated Disc
- □ Multiple Sclerosis
- □ Parkinsons
- □ Herpes/Shingles
- □ Chronic Pain
- □ Fatigue
- □ Sleep disorder

Miscellaneous:

- □ Allergies:_____
- □ Anaphylaxis
- □ Artificial Joints/Special Equipment
- □ Cancer
- □ Depression
- □ Diabetes : Type 1_____ Type 2_____
- □ Dizziness
- □ Epilepsy
- □ Fibromyalgia
- □ Gout
- □ Hemophilia
- □ Hearing Loss
- □ Lupus
- □ Stress
- □ Surgical Pins/Wires: _____
- □ Other:_____

Women:

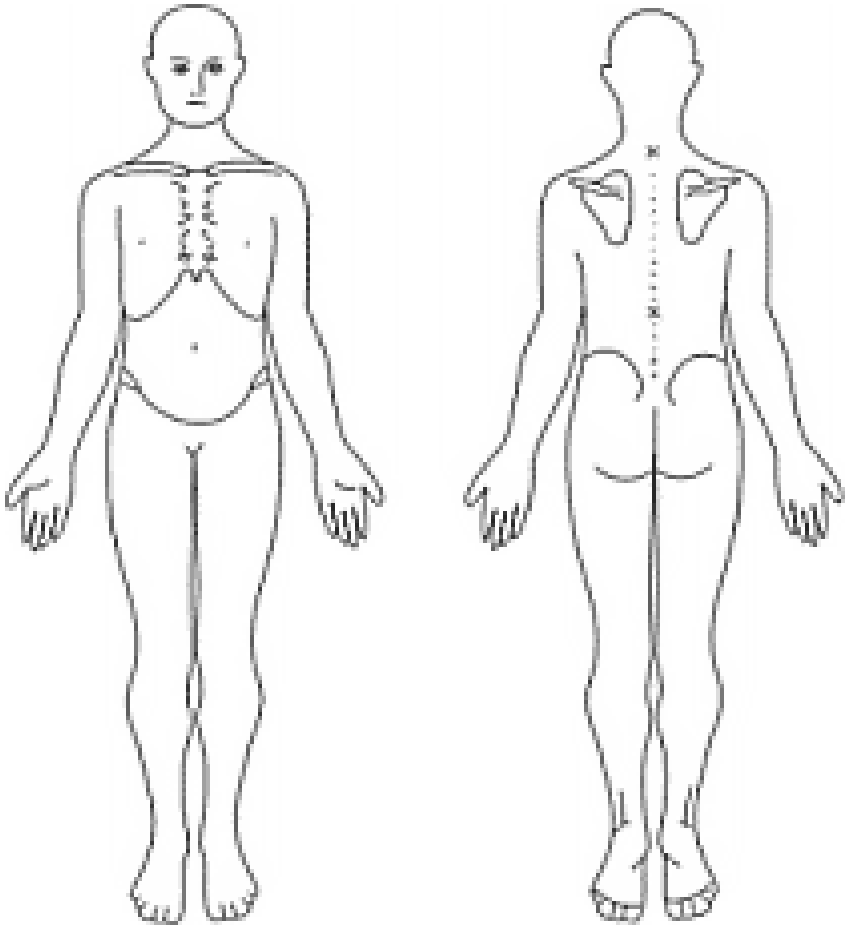
- □ Pregnant, due:_____
- □ Gynaecological Conditions: _____

Current Medications:_____

Surgeries (please list and date):_____

Injuries/Accidents (please list and date):

Please indicate with an 'X' any areas on the figure where you are experiencing pain. Please shade any areas you experience tension or discomfort.



Informed Consent to Treatment

Massage Therapy involves the manipulation of the soft tissues of the body, skin, muscle, ligaments and connective tissues, using techniques to produce therapeutic results.

With Massage Therapy, the client disrobes to their comfort level, and lies on the table between two sheets. Only the areas of the body being directly treated are uncovered one at a time. If at any time you are uncomfortable with the pressure or technique being used, you can tell the therapist (i.e. to decrease or increase pressure, irritating etc.). You can also stop the treatment at any time.

I have read the above and give consent for treatment.

24 hours notice is required for cancellation of an appointment to avoid charges.

Signature_____ **Date:**_____

For office use only

Date of Initial Health History:_____
Update 1:_____
Update 2:_____
Update 3:_____
Update 4:_____