Massage Health History Form

THE WELLNESS STUDIO

Name: _____ Gender: M F Date of Birth: _____

Address: _____ Postal Code:_____

Phone: Home: _____ Work: _____

Email Address: _____ Email Reminders: Y / N

Referred by: _____

Occupation: _____ Activities: _____

Medical Doctor: _____ Office Number: _____

Emergency Contact: _____ Number: _____

Chiropractor: _____ Naturopath: _____ Other: _____

Medications: _____

Supplements: _____

Allergies: _____

Previous Surgeries: _____

Previous Accidents/ Trauma:_____

History of Cancer: Y / N Type: _____ Has treatment been approved by your Dr? Y / N

HIV: Y / N Hepatitis: Y / N

Are you pregnant or trying to achieve? Y / N Due Date: _____

Current Health Condition

What is your present complaint? _____

Do you know the cause? _____

When do you experience this? _____
(morning, evening, sleeping, during/after activity, etc)

Describe symptoms: _____
(throbbing, burning, dull, cramping, numbness, tingling, sharp, shooting)

Duration of symptoms: _____
(constant, intermittent, brief)

What relieves? _____

What aggravates it? _____

Please check those which apply:

☐ Asthma	☐ Varicose Veins	☐ Eczema, Psoriasis	☐ Respiratory Infection
☐ Chest Pain	☐ Ringing in Ears	☐ Abdominal Pain	☐ Deep Vein Thrombosis
☐ Heart Attack	☐ Jaw (TMJ) Pain	☐ Constipation/Diarrhea	☐ Painful/Swollen joints
☐ Stroke	☐ Rheumatoid Arthritis	☐ Urinary Infection	☐ Crunching/Grinding Joints
☐ Bone Pain	☐ Osteoarthritis	☐ Cold Hands/Feet	☐ Morning stiffness
☐ Fatigue	☐ Osteoporosis	☐ Pins/Plates/Prosthesis	☐ High/Low Blood Pressure
☐ Weakness	☐ Diabetes Type I/II	☐ Colour changes in fingers & toes	☐ Headaches, Tension, Migraine
☐ Fibromyalgia	☐ Dizziness/Fainting	☐ Other: _____	☐ Other: _____

Informed Consent for Massage Therapy

I understand that therapeutic massage is provided at The Wellness Studio for the wellbeing of my body and mind. This includes stress reduction, relief from muscular tension, spasm or pain and/or for increasing circulation and energy flow.
I agree to communicate with my practitioner at any time I feel my well being (mental or physical) is being compromised.

I understand that the massage therapist do not diagnose illness, disease or any physical or mental disorders, nor do they prescribe medical treatment, pharmaceuticals or perform chiropractic manipulations. I acknowledge that massage therapy is not a substitute for medical examinations or diagnosis and that it is recommended that I see a primary health care provider for that service. I have disclosed all existing medical conditions I am aware of and understand that it is my responsibility to update my therapist of any changes to my health status.

If desired, CUPPING THERAPY can provided during your treatment with the Cupping Practitioner, Heather Mix, and it has been explained to me that there is the possibility of local discolouration following this therapy that includes clearing of stagnation and toxins from the body. I understand that these marks last from a few hours to a week following treatment. I understand that aggressive exfoliation and extreme exercise or temperature change can produce undesirable after effects following cupping.

I, _____ agree to allow the Cupping Practitioner, Heather Mix, to perform cupping on me and I have read and understood all of the information stated above.

I am aware that if I cancel without giving 24 hours' notice, or do not show up for my appointment, the full cost of the treatment will be charged to my account. I acknowledge that the cancellation / no show fee must be paid before I can make more appointments.

Date _____

Client's Name (print) _____

Client's/Guardian's Signature _____

Signature of Witness _____