Healing Essentials Therapeutic Massage

Name: _____ Date of Initial Visit: _____
Address: _____ Family Physician: _____
City: _____ Chiropractor: _____
Postal Code: _____ Referred by: _____
Phone (home): _____ (cell): _____ (work): _____
Date of Birth: (MM/DD/YY) _____
Occupation: _____
Name of Emergency Contact: _____ Relationship to you: _____
Phone Number of Emergency Contact: _____

Is this and SGI or WCB Claim? YES / NO (please circle)
Adjuster's Name: _____
Claim Number: _____

CASE HISTORY:

Have you seen a **Registered Massage Therapist** before? YES / NO (please circle)

Reason for massage treatment: _____
Do you have any concerns with the massage treatment or with touch in general? YES / NO (please circle)

Have you been diagnosed with a medical condition or illness? (eg: Diabetes, MS, cancer, tumours, stroke, heart disease, rheumatoid/osteoarthritis, seizure disorders, kidney disease, phlebitis/circulatory problems, pelvic inflammatory disease, HIV/AIDS,STD's, osteoporosis, high blood pressure, etc.) YES / NO (please circle)
If "YES" please specify _____
_____

Are you under any medical supervision for these conditions/illnesses? YES / NO (please circle)
If "YES" please specify _____
_____

Are you taking any medications? (eg: prescription drugs such as antihistamines, muscle relaxants, birth control, etc. or any over the counter drugs such as Tylenol, Advil, etc) YES / NO (please circle)
If "YES" please list the medication(s) and what it is for _____
_____

Do you have a history of physical injuries? (eg: from a car/motorcycle accident, sports injuries, slip and fall, dislocation, fracture, muscle strain/sprain, etc.) YES / NO (please circle)
If "YES", what? _____
(over)

Is there any other information that you feel is important to have a successful treatment? YES / NO (please circle)
If "YES" please explain _____

_____

Do you smoke? YES / NO

Do you consume alcohol? YES / NO
If "YES" how often? _____

Are you taking any vitamins or food supplements? YES / NO (please circle)
If "YES" please list _____

_____

What type of exercise do you do weekly? _____

Please check the following that apply to you:

*Presently have a fever	( )	*Painful muscle tension	( )	*Shortness of breath	( )
*Frequent headaches	( )	*Repeated chest pain	( )	*Flat feet	( )
*Frequent cold hands or feet	( )	*Sore aching joints	( )	*Dizziness/fainting spells	( )
*Neck pain	( )	*Unexplained muscular cramps	( )	*Varicose veins	( )
*Mid back pain	( )	*Blood clots	( )	*Bruise easily	( )
*Low back pain	( )	*Repeated ligament sprain	( )	*Tendon strain	( )
*Shoulder pain	( )	*Frequent cough	( )	*Joint dislocation	( )
*Frequent tingling lips/fingers	( )	*Frequent sore throat	( )	*Ear aches/infection	( )
*Blurred/tunnel vision	( )	*Sinus problems	( )	*Acne/cysts	( )
*Constant irritability	( )	*Psoriasis	( )	*Eczema	( )
*Excessive fear	( )	*Excessive anger	( )	*Anxiety	( )
*Communicable skin infection	( )	*Frequent skin infection	( )	*Depression	( )
*Frequent colds & flu	( )	*History of swollen glands	( )	*Frequently fatigued	( )

*Frequent "cracking/popping" of joints ( )
*Unexplained or sudden body weakness ( )

MEN: *Prostate/urinary infection ( )

WOMEN: *Frequent menstrual cramps ( )
*Pelvic inflammation/infection ( )
*Urinary infection ( )

Please list any symptoms presently or recently experienced: _____

_____

_____

WOMEN ONLY: Are you pregnant? _____ If so, how far along are you? _____ weeks.

****** ***ANY MISSED MASSAGE THERAPY APPOINTMENTS WILL BE CHARGED <u>FULL PRICE</u>. THE SAME APPLIES IF AN APPOINTMENT IS CANCELLED WITHOUT AS LEAST (2) HOURS NOTICE. IF YOU ARE LATE FOR AN APPOINTMENT YOU WILL ONLY RECEIVE THE REMAINING TIME AT FULL PRICE.*** ******

MARK SPECIFICALLY THE AREA OF PAIN OR DISCOMFORT ON THE DIAGRAMS BELOW: