HEALTH HISTORY

Qmassage
Living Life Hands On

IMPORTANT ▪ PLEASE READ

An accurate health history is important to ensure that it is safe for you to receive treatment. Please complete all fields and provide as much detail as possible when describing any injuries, health conditions, medications, or any other medical treatments you are receiving, or have received previously. If required, use the "Notes" section on page 2 to provide additional details and information. If your health status changes at any time please let us know. All information gathered is confidential except as required by law. None of your personal information will be shared without your express written consent.

Personal Details

First Name | Last Name | Date of Birth (Day / Month / Year) | Gender (Female / Male)

Address

City | Prov | Postal Code

Phone | Email | Preferred Contact Method (Phone / Email)

Occupation | How did you hear about us?

Physician's Name | Physician's Phone

Other Healthcare *(chiropractor, naturopath, physiotherapist, etc.)*

Health History & Current Status

Describe your current health status? (Good / Fair / Poor) Details

Have you suffered any previous injuries? (Yes / No) Details

Have you ever undergone any surgery? (Yes / No) Details

Are you receiving any other healthcare treatments? (Yes / No) Details

Do you exercise regularly? (Yes / No) Details

Please indicate any of the following conditions you are currently experiencing or have experienced in the past.

Soft Tissue / Joint

- ☐ Neck
- ☐ Back - Low
- ☐ Back - Mid
- ☐ Back - Upper
- ☐ Shoulders
- ☐ Arms
- ☐ Legs
- ☐ Knees
- ☐ Other *(provide details)*

Cardiovascular

- ☐ High Blood Pressure
- ☐ Low Blood Pressure
- ☐ Heart Attack
- ☐ Heart Disease
- ☐ Phlebitis
- ☐ Stroke / CVA
- ☐ Pacemaker *(or similar device)*
- ☐ Varicose Veins
- ☐ Other *(provide details)*

Respiratory

- ☐ Chronic Cough
- ☐ Shortness of Breath
- ☐ Bronchitis
- ☐ Asthma
- ☐ Emphysema
- ☐ Smoking
- ☐ Other *(provide details)*

Other Conditions

- ☐ Loss of Sensation
- ☐ Diabetes
- ☐ Allergies
- ☐ Epilepsy
- ☐ Cancer
- ☐ Arthritis
- ☐ Digestive Disorders
- ☐ Other *(provide details)*

Head / Neck

- ☐ Vision Problems
- ☐ Vision Loss
- ☐ Ear Problems
- ☐ Hearing Loss
- ☐ Headaches *(provide details)*
- ☐ Other *(provide details)*

Infections

- ☐ Hepatitis
- ☐ TB
- ☐ HIV
- ☐ Plantar Warts
- ☐ Other *(provide details)*

Women

- ☐ Menstrual Problems
- ☐ Menopausal
- ☐ Children
- ☐ Pregnant *(provide due date)*
- ☐ Other *(provide details)*

Skin

- ☐ Skin Conditions
- ☐ Skin Irritations
- ☐ Bruise Easily
- ☐ Other *(provide details)*

Primary Complaint

Why are you currently seeking massage therapy?

Have you had massage therapy previously? ○ Yes ○ No Details

What kind of pain are you experiencing?

What is the cause of the pain? How long have you had the pain?

How frequent is the pain? How intense is the pain? *(scale of 1-10)*

How would you describe the pain? *(achy, throbbing, burning, etc.)*

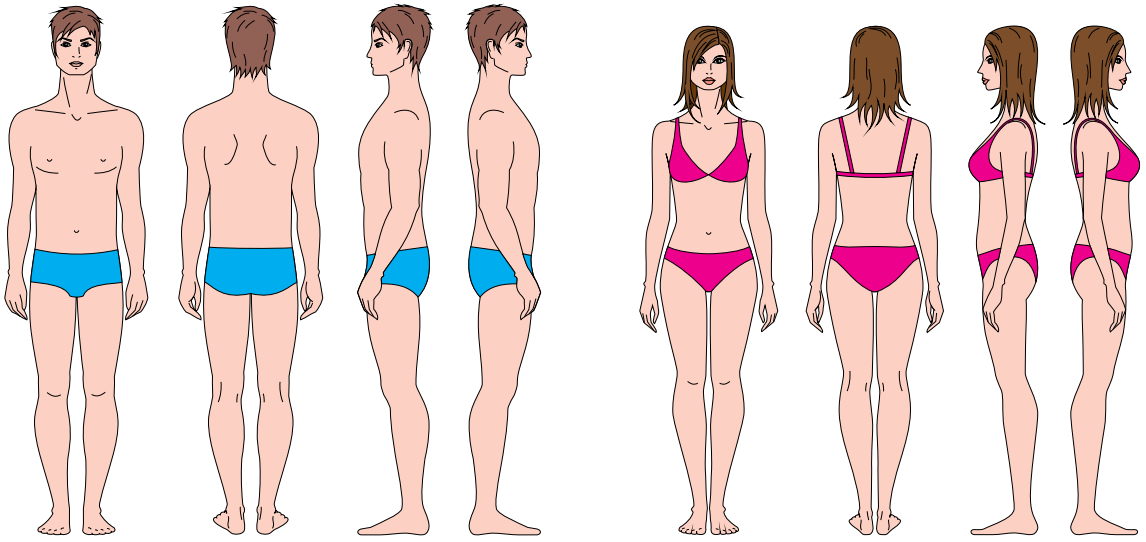
What makes the pain increase? What makes the pain decrease?

Is there a history of this condition? ○ Yes ○ No Details

Have you received any other treatment for this condition? ○ Yes ○ No Details

Are you taking any medication(s) for this condition? ○ Yes ○ No Details

Please use this diagram to indicate where you are experiencing pain or discomfort. Please be as accurate and specific as possible.



Notes

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 a table between two sheets. Only the areas of the body being directly treated are uncovered at one 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. 24 hours notice is required for cancellation of an appointment to avoid charges.

I have read the above and give consent for treatment.

Signature

Date Day Month Year

Print Form

Clear Form

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