SHIFRA
CENTRE FOR WELLNESS

Massage Health History Form

Name: _____ Date: _____

Address: _____ Postal Code:_____

Phone: Home: _____ Work: _____ Date of Birth:_____

Email Address (for massage discounts) _____ AHC # _____

Occupation: _____ Activities: _____

Medical Doctor: _____ Chiropractor: _____ Naturopath: _____

Medications: _____ Allergies: _____

Previous Injuries/Surgeries: _____

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

HIV: Y / N Hepatitis: Y / N

Are you pregnant? Y / N Due Date: _____

Referred by: _____

Current Health Condition

What is your present complaint?

_____

Do you know the cause?

_____

When do you experience this?

_____

(morning, evening, sleeping, during/after activity)

Describe symptoms:

_____

(throbbing, burning, dull, cramping, numbness, tingling, sharp, shooting)

Duration of symptoms:

_____

(constant, intermittent, brief)

What relieves?

_____

What aggravates?

_____

Please check those which apply:

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

Additional condition(s) not listed: _____

I declare the information on this form to be true and correct in all respects. I understand that the Massage Therapist will rely on the information given by me to provide safe treatment. If any information is not correct, I release the Massage Therapist from any and all claims arising out of any treatment provided. **Cancellation policy**: 24 hours notice is required for cancellation of appointments. If we do not receive sufficient time for cancellation, there is a no show fee of $20.00 for the first appointment, and thereafter a fee of half of the treatment cost for subsequent appointments missed. As well, please be aware that in order to provide timely service to all of our clients, late arrival to an appointment will result in shorter treatment duration.

Client Name: (Please print) _____ Date: _____

Client Signature: _____