



Client History & Consent

IMPORTANT!
please see reverse 

An accurate health history is important to ensure that it is safe for you to receive treatment. If your health status changes in the future, please let us know. All information gathered is confidential. Please be aware that you may request to alter or stop your treatment at any time for any reason and the therapist will comply with your wishes.

please print full name

home phone

work phone

date of birth (month, day, year)

emergency contact name

phone

mailing address

family physician

phone

city, province

postal code

how did you hear about us?

occupation

List any stress reduction exercises you do on a regular basis (include frequency):

What brings you in for a treatment?

Prioritize the areas of your body that you would prefer to receive treatment:

How would you describe your sleep?

In the last 2 hours, have you taken any:

- anti-inflammatory medication
- pain killers (aspirin, Advil, etc.)
- muscle relaxants
- mood altering medication (anti-depressants)

When is the last time you had massage/bodywork?

Current Medications

Surgeries: (include year and type of surgery)

Are you currently seeing a medical practitioner and for what reason?

Accidents: (year and type of accident & recovery)

I have read and understand the above and reverse page and give my consent to receive treatment.

signature

date



Client History & Consent Continued...

Please indicate if any of the following conditions apply to you (past or present):

Head & Neck

- | | | |
|---|---|---|
| <input type="checkbox"/> headaches (tension / migraine) | <input type="checkbox"/> head trauma/concussion | <input type="checkbox"/> hearing problems |
| <input type="checkbox"/> neck pain / injury / whiplash | <input type="checkbox"/> tooth/jaw/ear pain | <input type="checkbox"/> loss of balance / coordination |
| when? date: _____ | <input type="checkbox"/> vision problems (contacts/glasses) | <input type="checkbox"/> dizziness / vertigo |

Muscles, Joints & Skeletal

- | | | |
|---|---|---|
| <input type="checkbox"/> specific muscle / joint pain | <input type="checkbox"/> disc degeneration / herniation | where? (circle specific) |
| <input type="checkbox"/> tendonitis / bursitis | <input type="checkbox"/> scoliosis | <input type="checkbox"/> low / mid / upper back |
| <input type="checkbox"/> limitation of movement | <input type="checkbox"/> osteo / rheumatoid arthritis | <input type="checkbox"/> shoulders / arms |
| <input type="checkbox"/> work / sports injury | <input type="checkbox"/> osteoporosis | <input type="checkbox"/> sciatica / hip |
| <input type="checkbox"/> fractures / bone disease | | <input type="checkbox"/> leg / knee / ankle |
| when? date: _____ | | |

Respiratory System

- | | | |
|---|--|---------------------------------------|
| <input type="checkbox"/> smoker (heavy or light?) | <input type="checkbox"/> sinus problems | <input type="checkbox"/> bronchitis |
| <input type="checkbox"/> chronic cough | <input type="checkbox"/> allergies/hay fever | <input type="checkbox"/> tuberculosis |
| <input type="checkbox"/> shortness of breath | <input type="checkbox"/> asthma | |

Heart & Circulation

- | | | |
|--|---|--|
| <input type="checkbox"/> high blood pressure | <input type="checkbox"/> heart attack or stroke | Infectious Conditions: |
| <input type="checkbox"/> low blood pressure | <input type="checkbox"/> pacemaker | <input type="checkbox"/> HIV/AIDS |
| <input type="checkbox"/> poor circulation | <input type="checkbox"/> varicose veins | <input type="checkbox"/> Hepatitis type: _____ |
| <input type="checkbox"/> chest pain / angina / bruise easily | <input type="checkbox"/> edema / swelling | |
| | where? _____ | |

Skin

- | | | |
|--|--|--------------|
| <input type="checkbox"/> open sores / cuts | <input type="checkbox"/> rash / athlete's foot | where? _____ |
| <input type="checkbox"/> wart(s) | <input type="checkbox"/> eczema / psoriasis | when? _____ |
| | <input type="checkbox"/> other: _____ | |

Digestive System

- | | | |
|--|--|---|
| <input type="checkbox"/> constipation / diarrhea | <input type="checkbox"/> appetite changes | <input type="checkbox"/> irritable bowel syndrome |
| <input type="checkbox"/> nausea / vomiting | <input type="checkbox"/> rapid weight loss | <input type="checkbox"/> diabetes type: _____ |
| <input type="checkbox"/> heartburn / indigestion / gas | <input type="checkbox"/> abdominal pain | <input type="checkbox"/> complications? _____ |

Reproductive System

- | | | |
|---|---|--|
| Female: | | Men: |
| <input type="checkbox"/> menstrual pain / heavy / scant | <input type="checkbox"/> pregnant, due: _____ | <input type="checkbox"/> prostate problems |
| <input type="checkbox"/> menopausal problems | <input type="checkbox"/> other: _____ | <input type="checkbox"/> hormonal changes |
| | | <input type="checkbox"/> other: _____ |

Nervous System

- | | |
|--|---------------------------------------|
| <input type="checkbox"/> epilepsy / seizures | <input type="checkbox"/> Parkinsons |
| <input type="checkbox"/> numbness / nerve pain | <input type="checkbox"/> other: _____ |