Calgary Laser and Massage

HEALTH HISTORY FORM PLEASE COMPLETE FORM IN FULL

Name: _____ Date of birth: _____

Address: _____ City: _____ Postal code: _____

Home Phone: _____ Cell: _____ Work: _____

Email address: _____ Occupation: _____

Preferred contact: _____ Referred by: _____

How did you hear about us? _____

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 except as required by law. You will be asked to provide written authorization for release of any information.

☑ Please indicate conditions you are experiencing or have experienced.

Cardiovascular
- ❑ High blood pressure
- ❑ Low blood pressure
- ❑ Heart attack
- ❑ Heart disease
- ❑ Phlebitis
- ❑ Stroke / CVA
- ❑ Pacemaker or similar device
- ❑ Varicose veins

Respiratory
- ❑ Chronic cough
- ❑ Shortness of breath
- ❑ Bronchitis
- ❑ Asthma
- ❑ Emphysema
- ❑ Smoking

Head/Neck
- ❑ Vision problems
- ❑ Vision loss
- ❑ Ear problems
- ❑ Hearing loss
- ❑ Headaches
- ❑ Type: _____

Soft tissue/joint
- ❑ Neck
- ❑ Low back
- ❑ Mid back
- ❑ Upper back
- ❑ Shoulders
- ❑ Arms R / L
- ❑ Legs R / L
- ❑ Knees R / L
- ❑ Other: _____

Infections
- ❑ Hepatitis
- ❑ TB
- ❑ HIV
- ❑ Plantar warts
- ❑ Other: _____

Other Conditions
- ❑ Loss of sensation
- ❑ Diabetes
- ❑ Allergies
- ❑ Epilepsy
- ❑ Cancer
- ❑ Arthritis

Women
- ❑ Menstrual problems
- ❑ Menopausal
- ❑ Children: _____
- ❑ Pregnant
- ❑ Due date: _____

Skin
- ❑ Skin conditions
- ❑ Skin irritations
- ❑ Bruise easily

What is your general health status? _____

Current Medications _____ Condition it treats _____

Previous Surgery (date & nature) _____

Previous Injury (date & nature) _____ (e.g. dislocation/fracture/car accident)

Other Medical Conditions (e.g. digestive disorders, gynecological problems) _____

Of Special Note (presence of internal pins, wires, special equipment) _____

Primary Care Physician (name & phone number) _____

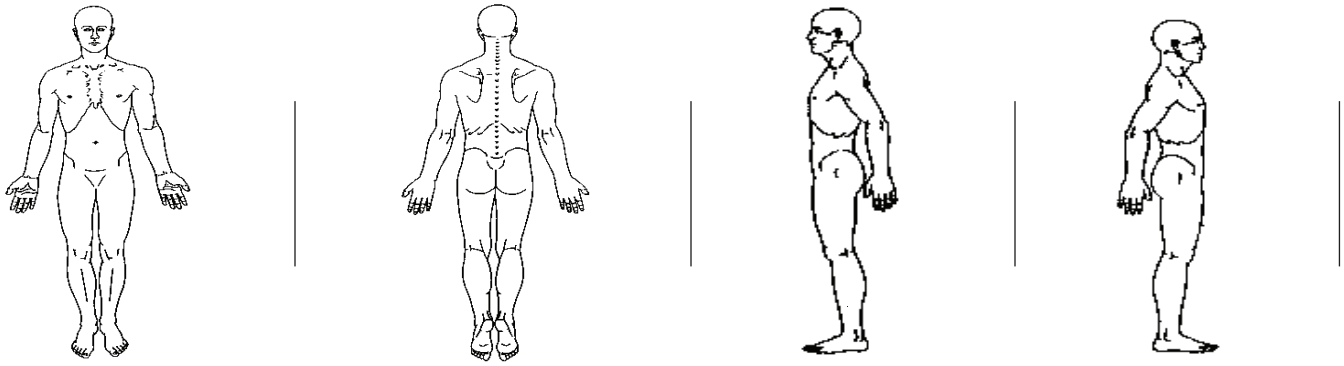
Other Healthcare (e.g. chiropractor, naturopath, physiotherapist) _____

Have you received massage therapy before? ❑ Yes ❑ No If yes, date of last visit _____

Do you exercise regularly (i.e. 3 times per week) ❑ Yes ❑ No If yes, what do you do _____

What is the reason you are seeking Massage Therapy? _____

MAIN COMPLAINT



Location of the pain. Please use the diagrams above. Try to be as specific as you can.

_____

Cause of the pain _____

How long have you had the pain? _____

How frequent is the pain? (all day/night/only when you get up) _____

How intense is the pain? (scale of 1 –10) _____

How would you describe the pain? (achy, throbbing, burning) _____

What makes the pain increase? _____

What makes the pain decrease? _____

What medications are you presently taking for the condition? (muscle relaxants, painkillers)_____

Is there a history of this condition? _____

Have you received any other treatment for this condition? If yes, please describe and comment on its success_____

_____

What results do you desire from your treatment? _____

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.

I have read the above and give consent for treatment. 24 hours notice is required for cancellation of an appointment to avoid charges.

Signature: _____ Date: _____