WESTERN CANADIAN PLACE
FITNESS CENTRE

CONFIDENTIAL HEALTH HISTORY FORM

Name: _____
Address: _____
_____ Postal Code:_____
Phone number: Cell (____)_____ Work (____)_____
Email:_____ Occupation:_____

Date of Birth: _____/_____/_____ Sex: M F Height:_____ Weight:_____

Emergency Contact Name:_____ Phone Number:_____

How did you hear about our clinic?_____

Have you received massage therapy before: _____YES _____NO

YOUR MEDICAL DOCTOR:

Doctor's Name: _____ Phone Number: _____

When did you last consult a doctor and for what reason? _____

PRESENT CONDITION AND HEALTH HISTORY:

Please indicate (✓) conditions you are experiencing or have experienced:

	High Blood Pressure		Asthma		Arthritis		Muscle/Joint Issues:
	Low Blood Pressure		Shortness of Breath		Osteoporosis		Neck
	Heart Attack		Emphysema		Bursitis		Back
	Heart Disease		Bronchitis		Sprain		Shoulder
	Stroke/CVA		Epilepsy/Seizures		Strain		Elbow/Wrist/Hand
	Congestive Heart Failure		HIV/AIDS		Fracture		Hip
	Anemia		Cancer		Numbness/Tingling		Knee
	Hemophilia		Tumors		Dizziness/Vertigo		Ankle/Foot
	Phlebitis/Varicose Veins		Edema/Inflammation		Headaches/Migraines		
	Diabetes		Allergies/Sensitivities		Insomnia/Sleep Difficulties		
	Digestive Conditions		Skin Conditions		Anxiety		Women: Pregnancy
	Vision or Hearing Loss		Poor Circulation		Excessive Stress		

Please list any other medical conditions not listed above:

_____
_____

Are you presently taking any medications (prescribed or over the counter)? _____YES _____NO

If yes, please list medication(s) and the condition for which it is being used.

_____
_____

Are you seeing any other health care professionals or receiving any other medical treatment?

_____
_____

Briefly list any surgeries or injuries you have experienced including the date:

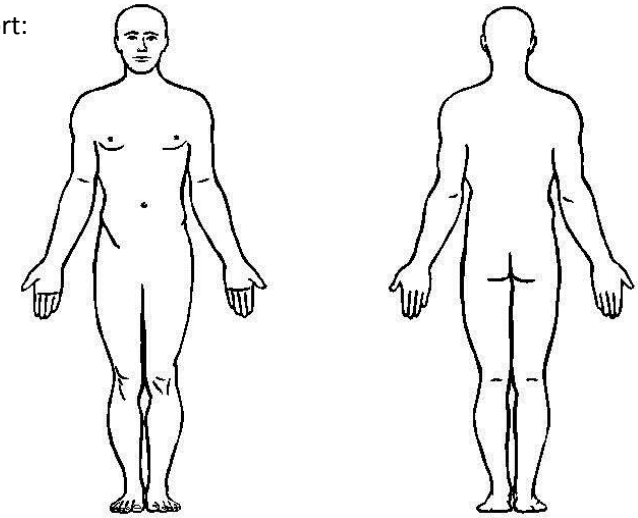
_____

_____

Primary reason for seeking massage therapy:_____

When did you first notice this issue? _____

On the drawing please indicate any areas of discomfort:



PHYSICAL ACTIVITY:

_____ Heavy _____ Medium _____ Light

Frequency: _____

Type: _____

Is there anything else that would be important for your massage therapist to know?

_____

_____

I understand that massage therapy is given here for the purpose of stress reduction; relief from muscular tension and for facial adhesions, spasm, or pain; or for increasing circulation.

I understand that the Massage Therapist does not diagnose illness, disease, or any other physical or mental disorder. As such, the Massage Therapist does not prescribe medical or pharmaceutical treatment, nor do they perform spinal manipulations. I clearly understand that massage therapy is not a substitute for a medical examination. It has been made clear to me that it is recommended that I see a physician for any physical ailment I might have.

I acknowledge and understand that the Massage Therapist must be fully aware of my existing medical conditions. I have completed my medical history form as provided by my Massage Therapist and disclosed all of those medical conditions affecting me. It is my responsibility to keep the Massage Therapist updated on my medical history. The information I have provided is true and complete to the best of my knowledge.

I understand that payment is expected at the time of the appointment unless previous arrangements have been made, and that if I fail to cancel an appointment 24 hours in advance, I will be charged for the missed appointment.

_____	_____
(Signature)	(Date)
_____	_____
(Signature)	(Updated)
_____	_____
(Signature)	(Updated)