IDEAL MASSAGE THERAPY

Name:_____ Telephone: (H)_____
Address:_____ (W)_____
_____ (C) _____
_____ Occupation:_____
Date of Birth:_____ Weight: _____ Height: _____
E-mail address_____ Recreational activities:_____
What brings you in for treatment? □ Relaxation □ Stress □ Injury □ Pain
Where did you hear about us?_____

CONFIDENTIAL HEALTH HISTORY: (Please check the conditions you experience frequently)
An accurate health history is important to ensure that it is safe for you to receive a massage treatment. Please let your therapist know if you health status changes. You will need to update this form at least every 12 months.

Head & Neck

□Headaches type:_____
□Vision problems □contact lenses
□Sinus □Dizziness/vertigo
□Frequent colds □Ear aches
□Allergies □Tooth/Jaw pain
□Hearing Problems □TMJ(TMD)

Skin

□Sensitive skin □Rashes
□Bruise easily □Contagious condition
□Cold sores □Swelling
□Fibromyalgia/chronic fatigue

Cardiovascular

Blood Pressure □Poor circulation
□High □Low □Phlebitis
□Heart disease
□Varicose veins (Dr. Diagnosed)

Respiratory

Smoking □Chronic cough
□Heavy □Light □Congestion
□Asthma □Shortness of breath

Muscles	**Side**	**Please Circle**
□Neck	L R	pain stiffness limited movement
□Shoulder	L R	pain stiffness limited movement
□Upper back	L R	pain stiffness limited movement
□Mid back	L R	pain stiffness limited movement
□Low back	L R	pain stiffness limited movement
□Arm	L R	pain stiffness limited movement
□Leg	L R	pain stiffness limited movement

Joint

□Elbow	L R	pain stiffness limited movement
□Wrist	L R	pain stiffness limited movement
□Hip	L R	pain stiffness limited movement
□Knee	L R	pain stiffness limited movement
□Ankle	L R	pain stiffness limited movement

□ Rheumatoid arthritis
□ Degenerative discs □ Fractures □Bursitis
□ Osteoarthritis

Uro/Genital

□Frequent urination
□Kidney/bladder
□Diabetes

Digestive

□Poor appetite
□Difficult digestion
□Constipation
□Diverticulitis
□Liver/Gall bladder

Women

Menstruation
□Painful
□Heavy
□Scant
Pregnant Due:_____
□Cesarean
□Menopause

Nervous System

□Fatigue
□Insomnia
□Depression
□Nervousness

Surgery/Injury

Type: _____ Date:_____

_____ _____

_____ _____

Current Symptoms _____

_____

_____

Doctor

_____ #_____

_____ #_____

Current Medications/Natural Remedies

_____

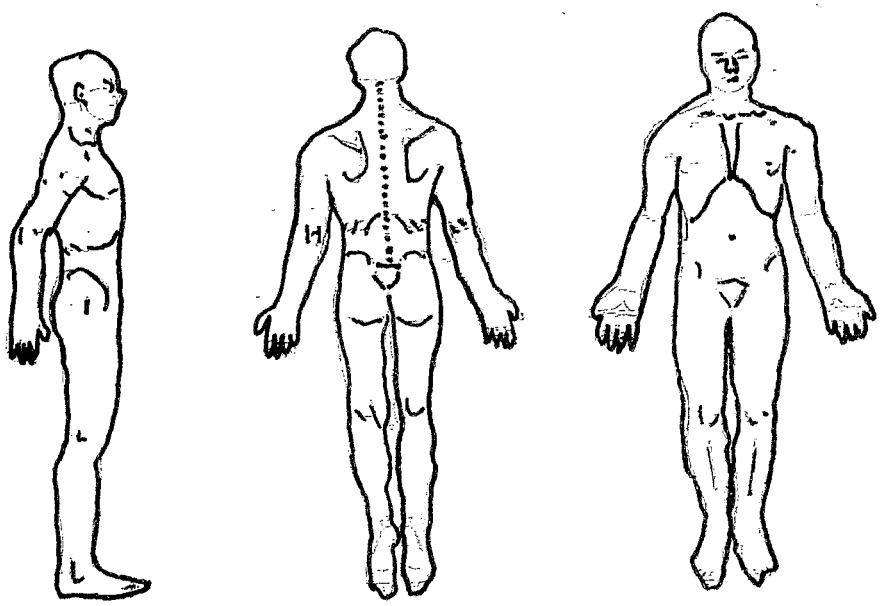
_____

_____

OTHER HEALTH CARE

Previous Massage	Chiropractic	Physiotherapy	Psychotherapy
☐Yes ☐No	☐Yes ☐No	☐Yes ☐No	☐Yes ☐No
Good Sleeping Patterns	**Regular Eating Habits**	**Regular Exercise**	**Osteopathy**
☐Yes ☐No	☐Yes ☐No	☐Yes ☐No	☐Yes ☐No

Kindly indicate where you are experiencing pain



- I acknowledge the information on this form is correct and complete.
- I understand that I have the right to ask my therapist to stop or modify the treatment at any time.
  Note: If you at any time have questions about the treatment or treatment plan please express your concerns as soon as possible
- I understand that all the information gathered for this treatment is confidential except as required by law or to facilitate assessment and/or treatment. Do you consent to Be. Massage contacting your health care provider(s) regarding your treatment? ☐Yes ☐No
- **Ideal Massage Therapy requires 24 hours notice to change or cancel an appointment. Failure to provide 24 hours notice will result in a 100% fee levied against your account and your booking privileges suspended until you clear you debit.**

Signature: _____ Date:_____