ideal
massage therapy
PEGGY ORMOND, RMT

Name:				Telephone (H):
Address:				(W):
				(C):
Date of birth:				Occupation:
E-mail address:			Height:	Weight:
Recreational activities:				
What brings you in for treatment?	Relaxation ☐	Stress ☐	Injury ☐	Pain ☐
Would you like to sign up for our newsletter?		Yes ☐	No ☐	
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		MUSCLES	SIDE	PLEASE CIRCLE
Headaches type:		☐ Neck	L ☐ R ☐	pain stiffness limited movement
Vision problems ☐	Contact lenses ☐	☐ Shoulder	L ☐ R ☐	pain stiffness limited movement
Sinus ☐	Dizziness/vertigo ☐	☐ Upper back	L ☐ R ☐	pain stiffness limited movement
Frequent colds ☐	Ear aches ☐	☐ Mid back	L ☐ R ☐	pain stiffness limited movement
Allergies ☐	Tooth/Jaw pain ☐	☐ Low back	L ☐ R ☐	pain stiffness limited movement
Hearing Problems ☐	TMJ(TMD) ☐	☐ Arm	L ☐ R ☐	pain stiffness limited movement
		☐ Leg	L ☐ R ☐	pain stiffness limited movement

SKIN			
☐ Sensitive skin	☐ Bruise easily	☐ Cold sores	☐ Fibromyalgia/chronic
☐ Rashes	☐ Contagious condition	☐ Swelling	☐ Fatigue

CARDIOVASCULAR			JOINT		PLEASE CIRCLE
☐ Blood Pressure	☐ High↑	☐ Low	Elbow	L ☐ R ☐	pain stiffness limited movement
☐ Poor circulation			Wrist	L ☐ R ☐	pain stiffness limited movement
☐ Heart disease			Hip	L ☐ R ☐	pain stiffness limited movement
☐ Phlebitis			Ankle	L ☐ R ☐	pain stiffness limited movement
☐ Varicose veins (Dr. Diagnosed)			☐ Rheumatoid arthritis		☐ Degenerative discs
			☐ Fractures	☐ Osteoarthritis	☐ Bursitis

Respiratory			
☐ Smoking:	Heavy ☐	Light ☐	☐ Chronic cough
☐ Asthma		☐ Congestion	☐ Shortness of breath

↑

Uro/Genital	Digestive	Women	Nervous System
☐ Frequent urination	☐ Poor appetite	Menstruation:	☐ Fatigue
☐ Kidney/bladder	☐ Difficult digestion	☐ Painful	☐ Insomnia
☐ Diabetes	☐ Constipation	☐ Heavy	☐ Depression
	☐ Diverticulitis	☐ Scant	☐ Nervousness
	☐ Liver/Gall bladder	☐ Pregnant – Due:	
		☐ Cesarean	
		☐ Menopause	

Surgery/Injury		Doctor	
Type:	Date:		#
			#
		Current Medications/Natural Remedies	
Current Symptoms:			

OTHER HEALTH CARE			
Previous Massage	Y ☐ N ☐	Osteopathy	Y ☐ N ☐
Chiropractic	Y ☐ N ☐	Physiotherapy	Y ☐ N ☐
Good Sleeping Patterns	Y ☐ N ☐	Psychotherapy	Y ☐ N ☐
Regular Eating Habits	Y ☐ N ☐	Regular Exercise	Y ☐ N ☐

- 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 Ideal 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 50% fee levied against your account and your booking privileges suspended until you clear you debit.**

Signature: ______________________________

Date: ______________________________