Chiropractic Associates Clinic,
1127 Lakewood Court North, Regina, SK, S4X 3S3

Massage Health History Form Date of first appointment:_____

Please print, fill out and bring to your first appointment

Name _____
(Last) *(First)*

PHN: _____ Date of Birth (M/D/Y) _____ Male/Female

Address _____City: _____ Province:____ Postal Code_____

Phone number (H)_____(W)_____(C)_____

Employer/Occupation _____

Family doctor:_____ Referred by:_____

Email address _____

Emergency Contact Name _____ Relationship _____

Emergency Contact phone number (H) _____ (W) _____ (C) _____

Are you being treated by any other health practitioners? _____

Have you received massage before? **Y N**Do you smoke? **Y N**Are you currently pregnant? **Y N**

Have you consumed any alcohol or pain meds in the last 12 hours?**Y N** Please indicate:_____

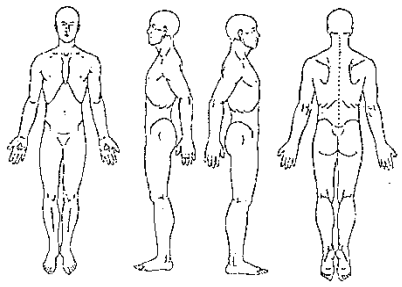
What is your Primary Concern? _____

Have you consulted your primary care practitioner about this concern?**Y N**

When did it begin? _____

Has it changed? How so? _____

What makes it better? _____ What makes it worse? _____



Do you experience pain, numbness or itch? Where? Please indicate on chart_____

How would you describe your pain (e.g. burning, dull ache, sharp, moving)? _____

Please mark your current level of pain: 0/_____/10

Please mark your current level of stress 0/_____/10

Please mark your current level of activity: 0/_____/10

Do you perform cardio exercise? **Y N** Do you perform strengthening exercises? **Y N** Do you stretch? **Y N**

During exercise, do you experience dizziness, headaches, difficult breathing, chest pain, extreme muscle soreness or weakness? **Y N** Please indicate: _____

How many servings do you consume in a day? Water _____ Coffee/tea _____ Alcohol _____

Please list any allergies you may have:_____
_____

Please list any surgeries or traumatic injuries you have experienced: _____
_____
_____
_____

Please list any medications/herbs/supplements/vitamins you are currently taking, and your reason for taking them: _____
_____
_____
_____

Have you been diagnosed or treated by a physician for any of the following?

Anemia DepressionBruise Easily

Anxiety Diabetes Neurological Condition

Allergies Difficulty SwallowingMultiple Sclerosis

Arthritis Digestive Disorders Numbness/Tingling

Asthma/Lung Disorders DizzinessOsteoporosis

Backaches/Bulged Disc Epilepsy/Seizures Psychiatric Condition

Bleeding Disorders/Clots Fibromyalgia Sleep Disturbance

Blood Pressure Fracture/Broken BonesSkin Conditions

Cancer Heart Condition Thyroid Disease

Chronic Fatigue TMJ (Lock Jaw)Varicose Veins

CholesterolHeadaches/Migraines Whiplash

Circulatory ProblemsHIV/Autoimmune Other: _____

Concussion/Head Injury Hepatitis/Liver Disease _____

Constipation Kidney Disorders

The information I have provided on this health history form is true and complete to the best of my knowledge.

Client name: _____ Client signature: _____

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Massage Therapy Consent Form

(Please read prior to your first appointment, and then sign in the presence of the Massage Therapist)

Massage Therapy is a manual therapy that involves the pressing and kneading of muscles and fascia with the intention of helping to improve circulation, relieve muscle tension and spasm, and to help facilitate healing and relaxation. The Massage Therapist endeavours to work at a level that is comfortable, safe and productive for the client. However some discomfort is possible, both during and after the treatment, as is muscle spasm, swelling and bruising. It is also possible for the client to experience some light headedness during the treatment, or even faint. In the event of light headedness or any other discomfort during the treatment, it is important that the client communicate these concerns to the Massage Therapist.

By signing this form, I acknowledge that:

I understand that the Massage Therapist is providing massage therapy services within their scope of practice as defined by the Natural Health Practitioners of Canada;

I consent to treatment by the Massage Therapist, for the purposes noted on my health history form, including assessments, examinations and techniques (including, but not limited to: stretching, acupressure, cupping, myofascial techniques, the application of heat) which may be recommended by the Massage Therapist. I may refuse the use of any technique at any time;

I acknowledge that the Massage Therapist is not a physician and does not diagnose illness or disease or any other physical or mental disorder. I clearly understand that massage therapy is not a substitute for a medical examination. It is recommended that I attend my personal physician for any ailments that I may be experiencing. I acknowledge that no assurance or guarantee has been provided to me as to the results of the treatment. I acknowledge that with any treatment there can berisks, and those risks have been explained to me. I assume those risks;

I acknowledge and understand that, in order to determine the best course of treatment and to best avoid side effects, the Massage Therapist must be fully aware of my existing medical conditions. I have completed my medical history form as provided by the Massage Therapist and have disclosed to the Massage Therapist 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 authorize the Massage Therapist to release or obtain information pertaining to my condition(s) and/or treatment to/from other caregivers or third party payers;

I have read the above noted consent and I have had the opportunity to question the contents and my therapy. By signing this form, I confirm my consent to treatment and intend this consent to cover the treatment discussed with me and such additional treatment as proposed by the Massage Therapist from time to time, to deal with my physical condition and for which I have sought treatment. I understand that at any time I may withdraw my consent and treatment will be stopped.

_____ _____

Client Name Client signature

_____ _____

Witness Date signed