MASSAGE THERAPY
CONFIDENTIAL HEALTH HISTORY FORM
3-276 Main Street Steinbach, MB R5G 1Y8

embody. WELLNESS STUDIO AND CLINIC

First name:_____ Last name: _____

Address: _____ Mobile phone #:_____

City:_____ Home phone #:_____

Province:_____ Postal code: _____ Email: _____

Date of birth: _____ Emergency contact person: _____

Gender: _____ Pronouns: _____ Relationship: _____

Occupations:_____ Emergency contact phone #:_____

_____ Do you have a primary health care physician? ☐Yes ☐No

Recreational activities: _____ Physician's name: _____

_____ Physician's phone #:_____

How did you hear about us? _____ Physician's address: _____

Please indicate any conditions you are experiencing, past or present.

ACCIDENT/INJURY

☐ Car Accident (Last 5 years)

Date:_____

Symptoms:_____

_____

☐Work/sport related

Date:_____

Date: _____

Symptoms:_____

_____

☐Whiplash:

Date: _____

Date: _____

☐Other:_____

_____

GASTROINTESTINAL

☐Irritable bowel syndrome (IBS)
☐Colitis
☐Gastroenteritis
☐Crohn's disease
☐Constipation/bloating
☐Other:_____

CARDIOVASCULAR

☐High/low blood pressure
☐Heart attack I Date: _____
☐Phlebitis/DVT
☐Stroke/CVA I Date: _____
☐Pulmonary emboli
☐Pacemaker
☐Heart disease
☐Angina
☐Varicose veins
☐Chronic congestive heart failure
☐Family history of any of the above

HEAD HISTORY

☐Tension
☐Migraines
☐Tooth/jaw/ear pain
☐Dizziness/fainting
☐Head trauma (ei: concussion)
Date:_____
☐History of headaches
Type:_____
☐Other:_____

INFECTIOUS DISEASE

☐Hepatitis
☐Infection/skin conditions
☐Tuberculosis
☐HIV
☐Other:_____

SOFT TISSUE/JOINTS & BONES (AREAS OF CONCERN)

☐Neck ☐Shoulders
☐Chest ☐Arms
☐Legs ☐Knees
☐Hips ☐Upper back
☐Mid back ☐Low back
☐Arthritis ☐Fractures

SKIN
☐Skin condition:_____
☐Bruise easily
☐Athlete's foot
☐Loss of sensation
☐Rash

RESPIRATORY
☐Chronic cough
☐Shortness of breath
☐Bronchitis
☐Asthma
☐Emphysema
☐Pneumonia
☐Sinus problems

OTHER CONDITIONS
☐Neurological condition
☐Epilepsy
☐Diabetes I Onset: _____
☐Allergies I Type: _____
☐Cancer I Type:_____
☐Family history of arthritis
☐Vision loss
☐Hearing loss
☐Insomnia
☐Hemophilia
☐Kidney/bladder problems
☐Dialysis
☐Overactive bladder
☐Osteopenia
☐Osteoporosis
☐Positional vertigo
☐Pins/wires/prosthetics
☐Medic alert bracelet
Specify:_____

MENTAL HEALTH
Indicate current stress level:

0 1 2 3 4 5 6 7 8 9 10

Not stressed Very stressed

☐Mental health disorder (anxiety, depression, ED, PTSD, etc.)
☐Other:_____
_____

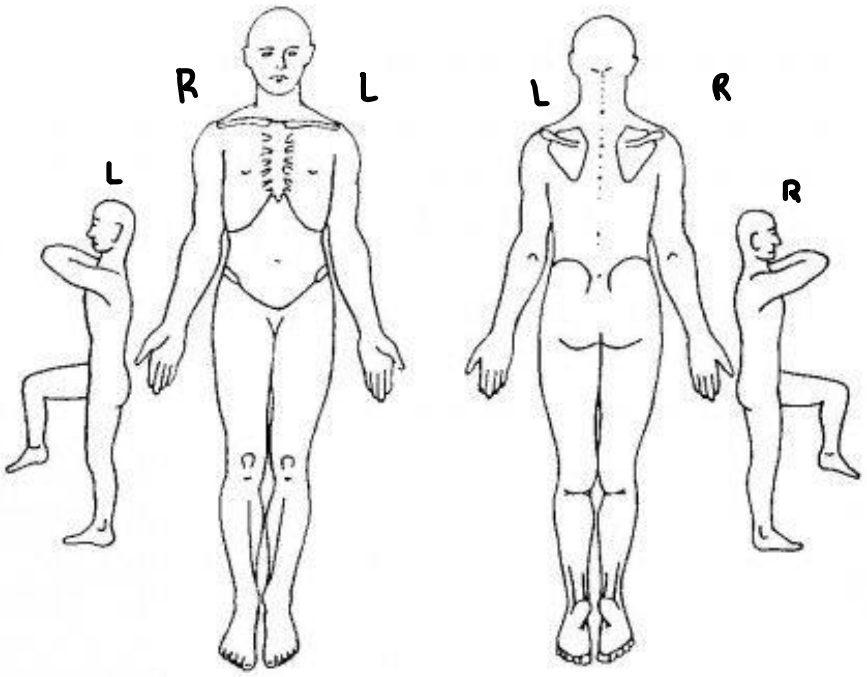
RECENT SURGERY (LAST 7 YEARS)
Type:_____ Date:_____
Type:_____ Date:_____
Current symptoms:
_____
_____

CURRENT MEDICATIONS
_____
_____
_____
_____

Is this your first ever massage treatment? ☐Yes ☐No General health status:_____

Desired outcome of today's treatment? (Relaxation/stress management, pain/injury rehab, overall wellness, etc):_____

On the diagram below, please identify any areas of irritation:



Primary complaints:

_____
_____

Key:
P = Pain/irritation
N = Numbness/Tingling
S = Stiffness in joint/muscle

Additional Information: *You can use this space to communicate any additional information such as preferred name, triggers, concerns, etc.*

_____

_____

CANCELATION & NO-SHOW POLICY

Minimum of **24 hours** is needed to cancel or reschedule any appointments. Failure to do so will result in a fee.

10% service fee to cancel/reschedule within **24 hours**
30% service fee for **1st no show**
100% service fee for **2nd no show**

Will require full payment before rebooking any future appointments.

☐ **I ACCEPT THESE TERMS**

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 and disclosed to the massage therapist my updated medical conditions. The information provided is true and complete to the best of my knowledge. I consent to be assessed and treated by my massage therapist, using a variety of examinations and techniques, for the conditions noted in my health history. I understand that I may withdraw my consent to assessment and/or treatment. I intend this consent to cover the assessment and treatment discussed. I understand that all information gathered is confidential and that I must give consent for my health records to be released to Embody Wellness Studio and Clinic.

☐ **I ACCEPT THESE TERMS**

Patient Name: (Please print)_____

Patient Signature:_____Date:_____

Signature of parent/guardian (under 18):_____Date_____

OFFICE USE ONLY