Confidential Case History

Name:		Chart #:
Date of Birth: _______ / ________ / __________ (Day/Month/Year)		
Address:		
City & Province:		Postal Code:
Home Phone:	Cell Phone:	
Occupation:	Email:	

Reason for Massage: Relaxation __________ Specific Discomfort ______________________

Please list any current medications: (including Aspirin, Ibuprofen, etc.)

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Please list any surgeries you have had: (Type/Date)

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Please mark an X for all conditions that apply:

( )Headaches
( )Back Pain
( )Neck Pain
( )Chronic Pain
( )Hearing Problems
( )Sinus Problems
( )Asthma or Lung Conditions
( )Abdominal or Digestive Problems
( )Constipation or Diarrhea
( )Heart/Circulatory Problems
( )Varicose Veins
( )Fibromyalgia
( )Tension or Stress
( )Depression
( )Neurological Disorder
( )Infectious Disease
( )Pregnancy (number of weeks ____)
( )Jaw pain, TMJ problems
( )Muscle or Joint Pain
( )Numbness/Tingling
( )Sprain or Strain
( )Arthritis, Tendonitis
( )Spinal Column Disorders
( )Osteoporosis
( )Diabetes
( )Hernia
( )High or Low Blood Pressure
( )Blood Clots/Thrombosis/Phlebitis
( )Fatigue
( )Sleep Difficulties
( )Cancer/Tumours
( )Epilepsy
( )Rash
( )Other Conditions not Listed
( )Allergies/Sensitivities (please list)____

Do you have any of the following: pins/plates/wires/artificial joints/pacemaker? (please describe)

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I certify that the information I have given is true and complete, and understand it is my responsibility to provide my therapist with any updates regarding the condition of my health. I understand the massage therapist does not diagnose illness, disease, or other physical or mental disorders. For medical diagnosis, it is recommended that I see a physician.

I understand that 24 hours notice is required for cancellation of appointments. If sufficient notice is not given, or an appointment is missed, the full treatment fee will be charged.

Signature:_____________________________________ Date: ______________________