INTEGRO MASSAGE AND WELLNESS HEALTH HISTORY

Name: _____

Address: _____City:_____

Province: _____Postal Code: _____

Phone #: (home) _____ (cell) _____(work)_____

Email: _____

Would you like to receive our email newsletters? Yes No Initial: _____

Date of birth: (YYYY/MM/DD) _____

Occupation: _____ General health status: _____

Have you received Massage Therapy before? Yes No

Did a health care practitioner refer you for massage therapy? Yes No

Current involvement with any other healthcare practitioners:

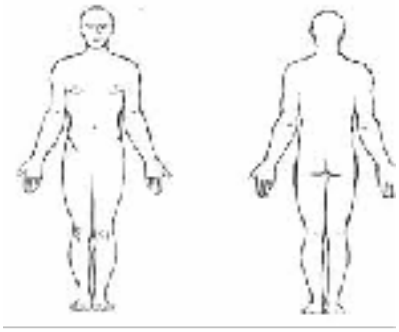
Chiropractor _____Physiotherapist_____

Naturopath _____ Other _____

How did you hear about our clinic? Friend: who may we thank? _____Google Walk-by

Primary Care Physician: _____ Address: _____

Reason for seeking Massage Therapy? _____



Please indicate the soft tissue and joint areas in which you are experiencing pain and or discomfort.

_____

Do you have any internal pins, wires, artificial joints or special equipment?
Where:_____

Surgery – date: _____

Nature: _____

Please indicate conditions you are experiencing or have experienced:

Cardiovascular:

- High blood pressure
- Low blood pressure
- Chronic congestive heart failure
- Heart attack
- Phlebitis/varicose veins
- Stroke/CVA
- Pacemaker or similar device
- Heart disease

Is there a family history of any of the above? Yes No

Respiratory:

- Chronic cough
- Shortness of breath
- Bronchitis
- Asthma
- Emphysema

Is there a family history of any of the above? Yes No

- Arthritis

  Type: _____

Is there a family history of any of Yes No

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Infections:

- Hepatitis
- Skin conditions
- TB
- HIV
- Herpes

Other Conditions:

- Loss of sensation, Where? _____
- Diabetes, onset: _____
- Allergies/hypersensitivity to what? _____

  Type of reaction: _____
- Epilepsy
- Cancer, where?_____
- Skin conditions, what? _____

Head/Neck:

- History of headaches
- History of migraines
- Vision problems
- Vision loss
- Ear problems
- Hearing loss

Women:

- Pregnant, due: _____
- Gynaecological conditions, specify? _____

Current Medications:_____

Condition it treats:_____

Do you have any other medical conditions? (E.g. Digestive conditions, haemophilia, osteoporosis, mental illness) Yes No what: _____

INTEGRO MASSAGE AND WELLNESS does require 24 hours notification for any cancellations, otherwise a late cancel charge will apply. If you fail to show up to your appointment without any notice the full charge will apply.

I understand the massage therapist will use my information to provide me with a safe and effective treatment plan, explain any risks and possible side effects, and contact other health care providers within my circle of care if need be. I hereby give my consent for massage treatment. I am aware that I can end or alter the treatment plan at any time. I understand that the information provided is held in confidence under the Personal Health Information Protection Act and The Personal Information Protection and Electronic Documents Act. If I would like to see a copy of the PHIPA Act it is available at the front desk.

Client signature: _____ Date: _____

Updated yearly: