INTEGRO MASSAGE & 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 Practitioner refer you for massage therapy? No Yes: _____
Current involvement with any other healthcare practitioners:
Chiropractor _____Physiotherapist_____

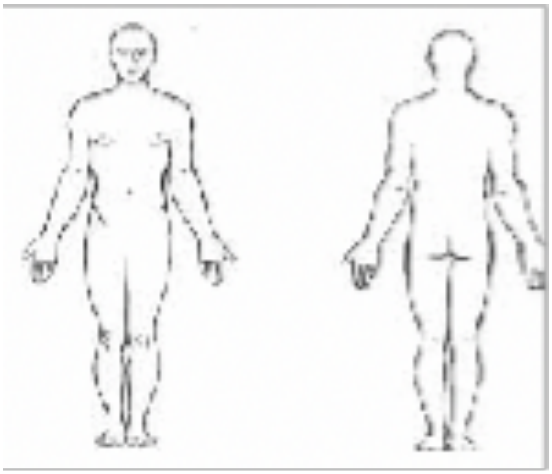
Naturopath _____Other _____

How'd you Hear about Clinic? Who may we thank? _____Google Walk-by

Primary Care Physician: _____ Address: _____

Reason for seeking Massage Therapy? _____

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



Any internal pins, wires, artificial joints or special equipment. Where _____
Surgery Type/Date _____
Timing/Nature of Injuries/Accidents _____

Please Indicate all the following you have or are experiencing..

Cardiovascular:
o High blood pressure
o Low blood pressure
o Chronic congestive heart failure o Heart attack
o Phlebitis/varicose veins
o Stroke/CVA
o Pacemaker or similar device
o Heart disease
Family history of any above? Yes No

Infections:
○ Skin conditions
○ TB
○ HIV
○ Herpes

Other Conditions:
○ Loss of sensation, Where? _____
○ Diabetes, onset: _____
○ Allergies/hypersensitivity _____
Type of reaction: _____
○ Epilepsy
○ Cancer, Type/Location: _____
○ Skin conditions, what? _____

Respiratory:
o Chronic Cough
o Shortness of Breath
o Bronchitis
o Asthma
o Emphysema
Family history of any above? Yes No
o Arthritis _____
Family history of any above? Yes No

Head/Neck
o History of Migraines
o History of Headaches
o Vision Problems
o Vision Loss
o Hearing Problems o Hearing Loss

Women:
o Pregnant, Due: _____
o Gynaecological Conditions:

Current Medications: _____

Condition it treats: _____

Do you have any other medical conditions (Ie; digestive, haemophilia, osteoporosis, mental illness? Yes No
If so, be specific: _____

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: _____