Balanced Health + Wellness

5014 51 Ave, Lacombe, AB T4L 1A2

STANDARD PATIENT INFORMATION FORM FOR MASSAGE TREATMENT

Date: _____

Name: _____ Date of Birth: mm/dd/yy _____/_____/_____

Address: _____City: _____ Postal code:_____

Phone #: (Business) _____ (Home) _____ (Cell) _____

Email: _____

Occupation: _____ Referred by: _____

Insurance Company: _____ Plan/Group#: _____ ID#: _____

Name of Policy Holder: _____ Relationship: _____

HEALTH HISTORY (Please list both past and present information)

Doctor: _____

Current Medications (conditions they treat): _____

_____

Surgeries (Please list and date): _____

_____

Please list the presence and location of any internal pins, wires, artificial joints of special equipment: _____

_____

Chiropractor: _____ Chiropractor Clinic Name: _____

List other current therapies (i.e. physiotherapy): _____

Motor Vehicle Accident? YES NO Date: _____

Other Accident(s)? _____ Date(s): _____

Reason for treatment: _____

Have you ever received a professional massage? YES NO

Please check off all applicable boxes below (past and current):

Cardiovascular

- o High blood pressure
- o Low blood pressure
- o Chronic congestive heart failure
- o Heart disease
- o Myocardial infarction
- o Phlebitis
- o Cardio-vascular accident
- o Stroke
- o Pacemaker
- o Varicose veins
- o Blood clots
- o Osteoarthritis
- o Lymph edema
- o Other

Infectious Diseases

- o Hepatitis
- o Tuberculosis
- o HIV
- o Other

Musculo-skeletal

- o Bone or joint disease
- o Tendonitis
- o Bursitis
- o Fractures
- o Osteoarthritis
- o Rheumatoid arthritis
- o Sprains/strains
- o Swelling
- o Stiffness
- o Spasms/cramps
- o Pain (check area)

__Jaw __Neck __Shoulder
__Elbow __Wrist __Hip
__Knee __Ankle __Back

Digestive

- o Constipation
- o Gas/bloating
- o Nausea/vomiting
- o Irritable bowel syndrome
- o Liver/gall bladder
- o Kidney/bladder
- o Other

Skin

- o Allergies (anaphylactic)
- o Rashes
- o Athletes foot
- o Warts
- o Cold sores
- o Eczema/psoriasis
- o Other (contagious)

Respiratory

- o Chronic cough
- o Bronchitis
- o Shortness of breath
- o Asthma
- o Emphysema
- o Smoking
- o Other

Reproductive

- o Pregnancy (trimester __)
- o PMS
- o Other

Nervous System

- o Herpes/shingles
- o Numbness/tingling
- o Chronic pain
- o Fatigue
- o Sleep disorder
- o Loss of sensation
- o Other

Other

- o Drug/alcohol addiction
- o Nicotine/caffeine addiction
- o Diabetes
- o Vision/hearing loss
- o Headaches/migraines
- o Cancer
- o Epilepsy
- o Allergies (please list)

Please Turn Over →

INDICATE AREAS OF PAIN OR DISCOMFORT

CLIENT CONSENT STATEMENT

I, _____ release the massage practitioner from an and all liability from problems arising from the treatment as a result of information not given or incorrectly given in this case history.

Signature (16 years of age or older):_____Date:_____

Parental/Guardian Signature:_____Date:_____

CANCELLATION POLICY

Any appointments cancelled prior to 24 hours before will not be subject to a cancellation fee.

Any appointments cancelled with less than 24 hours prior to the appointment will be subject to a cancellation fee of half the appointment cost.

Any appointments cancelled 5 or less hours prior to the appointment time will be subject to a cancellation fee of the full amount of the appointment.

Date of Initial Health History:_____
Update 1: _____
Update 2: _____
Update 3: _____
Update 4: _____
Update 5: _____

Therapist Notes: