INTEGRATE
MASSAGE & WELLNESS

CONFIDENTAL CLIENT INFORMATION

Name_____ Phone (home) _____

Sex M ☐ F ☐ Birthdate _____ Phone (work) _____

Address _____ Phone (cell) _____

City _____ Province _____ Postal Code _____

Email: _____

Occupation _____ Employer _____

Height _____ Weight _____

Medical History (list present/ previous illnesses, conditions, accidents, surgeries, fractured bone, etc. Please include dates)

_____

_____

_____

_____

What sporting/ exercise activities are you involved in: _____

_____

Please list current medications: _____

_____

_____

Medical Doctor: _____ Chiropractor: _____

Physiotherapist: _____ Other Health Professionals: _____

Previous Massage Experience: Y ☐ N ☐ Comments:_____

Purpose of this Appointment (Major Complaint): _____

_____

When did these symptoms appear: _____

Have you ever had same or similar conditions? Y o N o If yes, when and describe: _____

_____

How is this condition interfering with your daily routine? _____

_____

Is it progressively getting worse? Y ☐ N ☐ Constant? Y ☐ N ☐ Comes & Goes? Y ☐ N ☐

What makes it worse? _____

What makes it better? _____

Other complaints: _____

Confidential Health History

In order to protect yourself, your therapist, and others, honest disclosure is essential.

Head/ Neck:

- headaches
  - tension
  - migraine
- whiplash
- TMJ
- vision problems
- contact lenses
- earaches
- hearing problems
- sinus problems

Respiratory:

- rib injuries
- breathing difficulties

Cardiovascular:

- high blood pressure
- low blood pressure
- phlebitis
- dizziness
- heart disease
- varicose veins
- blood clots
- circulation problems

Skin:

- allergies
- bruise easily
- other _____

Muscles/ Joints:

- pain _____
- sprains
- strains
- spasms
- tears
- numbness/ tingling
- bursitis
- tendonitis
- arthritis _____

Digestive:

- constipation
- diarrhea
- gas
- digestion problems _____
- other _____

Skeletal:

- broken bones _____ _____
- osteoporosis date of diagnosis: _____
- spinal condition _____

Other:

- kidney/ bladder problems
- diabetes- type_____
- seizures _____
- herpes
- hepatitis
- HIV/ AIDS
- other contagious conditions _____

Women:

- menstruation problems _____
- pregnant? due date:_____
- number of children _____
- menopause problems _____

Cancellation Policy

Your appointment time is reserved especially for you. Any cancellations or rescheduling must be done with a minimum of six (6) business hours, or you will be charged the cost of your appointment. Thank you for your co-operation and understanding.

I understand that the information I have given on this form will be confidential and will be used for no other purposes than the therapist's records, and/ or for the emailing/ mailing of timely reminders. The contents of this form and related documents are the property of the therapist. I also verify that the above information is correct and complete.

Signature:_____ Date:_____